Manitoba

Law Reform Commission

Commission de réforme du droit

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REPORT ON SELF-DETERMINATION IN HEALTH CARE (LIVING WILLS AND HEALTH CARE PROXIES)

EXECUTIVE SUMMARY

The Manitoba Law Reform Commission's Report on *Self-Determination in Health Care (Living Wills and Health Care Proxies)* proposes a new method for the expression of wishes respecting health care: the health care directive. This new method would allow competent individuals to determine in advance the medical treatment to be administered to themselves should they later lose the capacity to make health care decisions. It would also allow them to appoint another person to make health care decisions on their behalf after they have lost the capacity to make those decisions themselves. The Report discusses why such a mechanism is needed, how it could be used, its effect and the details of implementation.

The following summarizes the major recommendations of the Report.

BACKGROUND

Competent individuals have the right to determine what is to be done to their own bodies, including what current medical treatment will or will not be administered. In general though, they lose this right of self-determination when they lose the capacity to make their own decisions about health care. At that point, individuals cannot be assured that instructions which were given by them prior to the incapacity will be followed. Furthermore, the law does not allow individuals to name others to make health care decisions on their behalf if they later lose the ability to make their own decisions. Documents which attempt to achieve those goals and which are commonly available in the United States (variously known as living wills, advance directives and durable powers of attorney for health care) are rarely accepted in Canada.

In July 1990, the Commission distributed a Discussion Paper which asked whether there was a need for reform is this area. The Discussion Paper received a very strong response and

was widely circulated. Respondents indicated that a mechanism should be introduced to permit individuals to exercise control, while competent, over the medical treatment to be administered in the event of becoming incompetent. The Commission agrees that such a mechanism should be developed.

THE MECHANISM: THE HEALTH CARE DIRECTIVE

The Commission proposes that the law should recognize a new document, to be called the health care directive. Every person who has the capacity to make health care decisions for himself or herself should be able to make one. The health care directive would be used by an individual to set out his or her wishes for future medical treatment, to name another person (known as a health care proxy) to make health care decisions on his or her behalf, or both.

GIVING EFFECT TO HEALTH CARE DIRECTIVES

Coming Into Force Health care directives would become effective when the maker loses the capacity to make and communicate his or her own health care wishes and would remain effective for the duration of the incapacity. Any relevant wishes set out in the health care directive would first be given regard. If the maker's wishes in the health care directive are not relevant to the health care decision to be made or are ambiguous, the health care proxy, if one is appointed, would be authorized to make decisions. In making them, the health care proxy would be obliged to follow the maker's wishes which were expressed prior to the incapacity and, if they are not known to him or her, the proxy would have to make decisions according to what in his or her opinion is in the best interests of the maker.

Scope The scope of health care directives would be very broad, encompassing any care, treatment, service or procedure to maintain, diagnose, treat or provide for an individual's physical or mental health or personal care. However, proxies would not be permitted to consent to *inter vivos* tissue donation, medical treatment whose primary purpose is research and non-therapeutic sterilization unless specifically authorized to do so by the maker in the health care directive.

The Health Care Directive: "As Effective As" The key to the Commission's proposals is the manner in which health care directives would be made binding. The Commission proposes that the instructions contained in the health care directive or given by the health care proxy should be as effective as the instructions which could have been given by the maker while

competent. As a result, the instructions in a health care directive or given by a health care proxy to something to which a competent person cannot consent (such as euthanasia) would not be given effect. This also means that the consequences of non-compliance with a valid instruction would be the same as the consequences of non-compliance with instructions given by a competent individual: the civil law remedy of damages for battery, and professional discipline.

Protection from Liability Proposals are made to ensure that the wishes of the maker are followed and given priority over the wishes of others. For example, no person or court should be able to review a health care proxy's decision unless it can be shown that the proxy is not acting in good faith or in accordance with the maker's wishes. Those acting in good faith under the authority of a health care directive or the instructions of a health care proxy should be protected from lawsuits. Health care proxies would be protected from liability for acting in good faith in accordance with the authority conferred upon them by health care directives. However, no one would be exempt from liability for negligence in carrying out the instructions in a health care directive.

IMPLEMENTING HEALTH CARE DIRECTIVES

Execution Execution requirements for health care directives should be as simple as possible, to ensure that they are accessible to everyone who wishes to make one while recognizing the need for reliability. Therefore, they should only be required to be in writing and signed by their makers. Persons who are physically unable to execute one should be allowed to have a substitute sign on their behalf, in which case a witness should be required. The health care proxy should also show his or her willingness to accept the position by consenting to the appointment in writing.

Qualifications of Maker and Proxy Everyone with the capacity to make health care decisions should be allowed to make health care directives. To assist health care professionals who will want to know whether a health care directive is valid, the Commission proposes a presumption. In the absence of other evidence, they may assume that a person 16 years of age or older has the capacity to execute a health care directive and that a person under 16 lacks the capacity. A directive made by a person under 16 could still be given effect if there were adequate evidence that he or she had the capacity to make health care decisions when the directive was executed. Similarly, a directive made by someone 16 or older could be invalidated by evidence of lack of capacity.

Making health care decisions for someone else requires a higher level of maturity than does making one's own health care decisions and, therefore, a health care proxy should be 18 years of age or older.

Form of Health Care Directive Individuals should be able to use any form and any words which clearly express their wishes for future medical treatment. This would prevent health care directives from being invalidated for non-compliance with a mandatory form. However, suggested forms should be provided as a guide for individuals in the use of health care directives. The Report sets out two possibilities.

Revocation Individuals should be able to revoke their health care directives while they have the capacity to execute new ones. Revocation should be by new document or by physical destruction.

Onus on Maker The onus of making known the existence or revocation of a health care directive should rest on the maker. No one should be liable for not acting in accordance with the maker's wishes if he or she is not aware of the maker's health care directive or its revocation.

Implementation A draft Act setting out the Commission's recommendations is contained in the Report. The Commission also suggests that public education programmes should follow the passage of legislation authorizing health care directives and should continue on an on-going basis.

RELATIONSHIP WITH THE COMMON LAW

The common law presently recognizes some directions given in advance in respect of future medical treatment. The Commission's proposed scheme would not affect the legality of such directions, nor would it impede the courts from expanding upon them.

CONCLUSION

The introduction of health care directives should benefit patients and health care professionals. Patients would gain increased control over their lives and their health care. Health care professionals would be given a reliable method of learning their patient's wishes and, where a health care proxy is appointed, a substitute decision maker with legal authority. For many people, the health care directive will be an appropriate, effective and welcome innovation for the expression of health care wishes.

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in Health Care
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CHAPTER 1

INTRODUCTION

The Manitoba Law Reform Commission undertook a project to determine whether the law should recognize a mechanism by which competent persons could give instructions in advance about the treatment that they wanted or did not want administered if they later became unable to convey their wishes.[1] Such mechanisms are commonly known as living wills, advance directives and durable powers of attorney for health care.

In order to elicit opinions, we prepared a Discussion Paper setting out this and other related issues and distributed it to individuals and organizations who would be interested in the issues raised. Our search for comments and opinions was further aided by the significant media coverage which the publication of the Discussion Paper received. In mid-July, 1990, our Executive Director, Jeffrey Schnoor, was a guest on Questionnaire, CBC Radio's afternoon phone-in programme and, soon after, the CTV National News reported on it. The public reaction which followed was gratifying; we received hundreds of requests for copies of the Discussion Paper. To date, approximately 600 copies have been distributed.

By early February, 1991, we had received 35 written responses; they came from the medical community, religious organizations, civil rights groups, seniors groups and private citizens. The Commission would like to thank the respondents for their thoughtful consideration of the issues and the time which they took in putting pen to paper; their submissions were invaluable to our deliberations.

Additional insight on the issues raised in the Discussion Paper was obtained when Mr. Schnoor and Legal Counsel, Iris Allen, accepted an invitation to speak at Toronto's Baycrest Centre for Geriatric Medicine and the University of Toronto's Centre for Bioethics in February, 1991. We would like to thank Drs. Michel Silberfeld and Peter Singer for their kind invitation. The visit resulted in our gaining important new perspectives on the issues before us.

The Commission would also like to thank Professor Barney Sneiderman and Drs. Brian Kirk, Paul Henteleff and Elizabeth Boustcha of Winnipeg for the assistance which they provided to us in the early stages of this project.

This final Report might look unfamiliar to those of you who have read our Discussion Paper; it represents a significant evolution from that document. In light of the direction which we have taken in this Report, it has become unnecessary to address specifically each issue raised in the Discussion Paper. Other issues which are discussed evolved as a result of the ideas which were generated from the responses, the discussions in Toronto and our own deliberations.

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[1]We had also considered whether legislation should set out a hierarchy of persons whose consent would be sought where individuals, by reason of choice, inadvertence or incapacity, had not given advance instructions. However, because of the size of such expanded terms of reference, we decided to narrow the focus of the project to the issue of self-determination and personal autonomy: providing a mechanism for competent individuals to determine for themselves what future medical treatment they will have or not have and who they wish to make future medical treatment decisions on their behalf. We decided that, following completion of this Report, we would commence a process of consultation to determine the advisability of a further project on this matter.

Chapter 2 of this Report focuses on general principles; it sets out our central recommendations for a new legal mechanism to give effect to decisions respecting future medical treatment. Chapter 3 discusses issues of implementation, such as qualifications for executing the new document which we envision, the method of executing it and the method of revoking it. Chapter 4, which sets out a draft Act and annotations showing how our proposals would work in practice, ties our Report together; in some ways, it is the foundation of this Report. Chapter 5 concludes our Report and summarizes our recommendations.

Finally, we have attached several appendices: Appendix A restates our draft Act, without annotations; Appendix B contains two sample forms; Appendix C sets out a list of the individuals and organizations to whom we sent copies of the Discussion Paper and those who responded; and Appendix D (the coloured pages) is a reprint of our Discussion Paper.

CHAPTER 2

GENERAL PRINCIPLES

A. THE CASE FOR REFORM

Competent individuals have the right to determine what is to be done to their own bodies, including what medical treatment will be administered or not administered. This principle is called the right to self-determination, or the right to individual autonomy. As one set of authors stated:

> There is a broad ethical, legal, and medical consensus that competent adult patients have the right to determine the course of their medical care. In particular, patients have a fundamental ethical and legal right to refuse all proposed treatments including life-sustaining medical treatments. In ethics, this right is based on the principle of individual autonomy. In law, it is based on the common-law right to be free from unconsented bodily invasion. . . .[1]

In general though, the law has not enunciated a corresponding right for individuals to determine their future treatment. Although there has recently been some movement in the law,[2] a competent individual generally cannot give binding instructions in advance about the medical treatment which he or she does or does not wish to have administered in the event of becoming incompetent to give instructions about medical treatment; there is no assurance that such instructions will be followed. The practical effect is that after an individual becomes incompetent, whether by reason of accident, illness or age, family or friends are usually asked to make treatment decisions on the person's behalf. In unusual circumstances, the approval of a judge of a superior court might be sought.

With each advance in medical science, this responsibility becomes more onerous for family and friends. Individuals who once faced quick and certain death can now be kept alive for considerable periods of time. Many fear that they will languish for months or even years, perhaps in a vegetative state, unable to control their medical treatment. They fear that they will be subjected to procedures which may save their lives, but reduce or destroy the quality of that life. Choices may be made on their behalf which they would not have approved. The fear of loss of control over their medical fate is coming to equal, and perhaps even surpass, people's fear of death itself.

To address these concerns, we asked in our Discussion Paper: should the principle of self-determination which governs competent individuals also benefit individuals who were competent once but who have subsequently become incompetent to determine their own medical treatment? The responses revealed a consensus of opinion on this question; respondents agreed that there was a need for a mechanism to permit competent individuals to determine, while still competent,

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[1] P.A. Singer and M. Siegler, "Elective Use of Life-Sustaining Treatments in Internal Medicine" (1991), 36 Advances in Internal Medicine 57 at 65 [reference within the quoted text omitted].

[2] In *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 (Ont.C.A.), the Ontario Court of Appeal affirmed the right of a Jehovah's Witness to refuse, in advance, while competent, the administration of blood or blood products. A card to that effect was found in Mrs. Malette's purse.

the medical treatment to be administered should they become incompetent to make those decisions for themselves. Moreover, respondents from the medical community favoured the concept of a binding mechanism. We agree that such a mechanism should be developed.

Two mechanisms have found favour in the United States and Australia. There, legislation has been enacted to enable competent individuals to make two documents: one in which they can specify their wishes for future medical treatment and another in which they can appoint an individual to make medical treatment decisions on their behalf. These documents become effective in the event that their makers become unable to make these decisions for themselves. However, the emphasis in these jurisdictions has been on terminal illness; that is, in most jurisdictions, an individual's instructions about future medical treatment are effective only when the person becomes terminally ill. The underlying assumption in these jurisdictions seems to be that there is a need only for documents which can be used to direct the withdrawal of medical treatment, so that terminally ill patients can die a "natural death". In addition, in some of these jurisdictions, limits are placed on the type of treatment over which control can be exercised and on who can exercise this control. These limits serve to prevent the refusal of life-prolonging treatment in certain situations. For example, some statutes limit or completely deny the effectiveness of a refusal of nutrition, hydration or palliative care; some limit or deny the effectiveness of the advance instructions of a pregnant woman.

Although we understand the emotional factors which would lead legislators to focus on the desire by some terminally ill patients to "pull the plug", it seems to us that this narrow approach overlooks many who would also wish to control their medical treatment. A regime which respects only the future treatment wishes of the terminally ill ignores persons who are involved in sudden, catastrophic accidents.[3] It also ignores persons who wish to express a consent to treatment, rather than a refusal, and those who simply wish to express a preference for one form of treatment over another.

Like many of our respondents, we favour an approach which is broader than that typically found in the American and Australian models. The law presently accepts that individuals can control their current medical treatment. It is reasonable and consistent that, to the extent possible, individuals should have the same control over their future medical treatment. Just as they can now consent to treatment, refuse treatment or choose one treatment over another, they should be able to do the same in respect to future care. Just as the principle of self-determination guides the law in respect to current medical care, so should the principle of self-determination guide the law in respect to future medical care.

RECOMMENDATION 1

The law should be reformed to permit the creation of a mechanism which would give legally binding effect to the wishes of a person, not now competent to make decisions about medical treatment, which were expressed when he or she had the capacity to make health care decisions.

The more difficult challenge is devising a mechanism which is simple and effective. It must be accessible to the average person and meaningful to health care professionals. In the balance of this Report, we set out our proposals.

[3]It is ironic that many of the American "death with dignity" statutes were inspired by the tragedy of Karen Ann Quinlan, yet most of them would not have recognized any advance directive which she might have made, since she was never terminally ill.

B. THE MECHANISM: THE HEALTH CARE DIRECTIVE

We propose that the law recognize a new method for the expression of health care decisions, which we will call a health care directive. Every person who has the capacity to make health care decisions for himself or herself should be able to make such a document. An individual who chooses to make a health care directive (the maker) would be able to set out his or her wishes respecting future medical treatment. However, in setting out these instructions, the maker cannot possibly anticipate every eventuality; furthermore, the maker's instructions may sometimes lack clarity. In order to address these problems, the maker should also be permitted to name in the health care directive another person or persons (whom we will call a health care proxy) to make health care decisions on his or her behalf. In light of the significant power and responsibility which is delegated to the health care proxy, we expect that the proxy will normally be a person whom the maker knows well and trusts.

RECOMMENDATION 2

The health care directive should be recognized as a mechanism to give legal effect to the expression of future health care wishes.

RECOMMENDATION 3

Every person who has the capacity to make health care decisions should be permitted to make a health care directive.

RECOMMENDATION 4

The health care directive should be a document in which the maker can:

(a) give or refuse consent to future medical treatment; and/or

(b) appoint one or more persons (a health care proxy) to make health care decisions on his or her behalf after he or she no longer has the capacity to make those decisions.

Although individuals should be free, if they so wish, to use health care directives for the sole purpose of setting out future treatment wishes or for the sole purpose of naming a health care proxy, health care directives should be capable of accomplishing both tasks. A requirement to use two separate documents to effect the two purposes would ignore their close relationship and would create an unnecessarily complex mechanism that might frustrate the intentions of unwary makers.[4]

C. GIVING EFFECT TO HEALTH CARE DIRECTIVES

1. Coming Into Force

Health care directives would become effective once the maker has lost the capacity to make and communicate health care decisions for himself or herself and would remain effective for the duration of that incapacity. Where the wishes of the maker set out in the health care directive are relevant to the health care decision to be made and are stated clearly, they would

[4]Suppose we insisted that future treatment wishes must be expressed in an "advance directive" and that the appointment of proxies must be contained in a "durable power of attorney for health care". What happens if an individual uses the form prescribed for an "advance directive", but actually attempts to name a proxy? The chances of a finding of invalidity would be increased further if different execution requirements applied to the two documents.

then be given legal effect. In these circumstances, the health care proxy, if one is appointed, would not be called upon. If, however, the wishes set out in the health care directive are not relevant to the health care decision to be made or are ambiguous and require interpretation, the health care proxy, if one is appointed, would be legally authorized to make decisions on the maker's behalf.

RECOMMENDATION 5

Upon the maker ceasing to have the capacity to make and communicate health care decisions and for so long as the maker lacks this capacity, the instructions contained in the health care directive should be given legal effect and, where there are no relevant instructions in the health care directive or those instructions are unclear, the instructions of the health care proxy, if any, should be given legal effect.

In giving those instructions, the health care proxy would be under an obligation to make those decisions in accordance with his or her interpretation of the maker's wishes expressed in the health care directive and any other wishes known to the health care proxy and expressed by the maker prior to the incapacity. If the health care proxy did not know of any such wishes, then the proxy would be obliged to decide in accordance with what he or she considered to be in the best interests of the maker. The determination of the maker's best interests should be made on a subjective standard, based not on a determination of the maker's best interests by a disinterested bystander, a physician or a court but on the proxy's perception of those best interests. The proxy should consider whatever factors he or she thinks are appropriate. For example, the proxy may wish to consider factors other than medical ones, such as the religious or ethical values of the maker. However, the choice of relevant considerations should be in his or her sole discretion. This is, after all, consistent with the reasons behind the delegation of authority from the maker to the health care proxy: trust and confidence that the proxy knows the maker well and will make the decisions which the maker would have wanted.

RECOMMENDATION 6

A health care proxy should act in accordance with the maker's wishes, if they are known, and in accordance with what he or she considers to be in the best interests of the maker if the maker's wishes are not known. The determination of the maker's best interests should be in the sole discretion of the health care proxy.

Medical treatment would be defined very broadly to mean any care, treatment, service or procedure to maintain, diagnose, treat or provide for an individual's physical or mental health or personal care. This expansive meaning flows from our guiding principles of autonomy and self-determination; we do not wish to limit the directions which can be given in a health care directive or by a health care proxy. However, there are certain non-therapeutic procedures which call for special treatment. *Inter vivos* tissue donation,[5] medical research[6] and non-therapeutic sterilization[7] will rarely be contemplated by makers when delegating decision-making powers to proxies. Furthermore, such procedures will usually be of benefit to others, rather than to the maker; before delegating the power to make decisions about such procedures, a maker should be very confident in the ability of the proxy to make them solely in his or her interests. A further consideration applies to non-therapeutic sterilization. The Supreme Court of Canada has ruled

[5]E.g., the donation of a kidney, bone marrow or skin from one living person to another.

[6]E.g., the administration of an experimental, unproven medication.

[7]E.g., sterilization for the purpose of contraception.

that a court can never give consent on behalf of an incompetent person to such a procedure, even under the court's *parens patriae* jurisdiction.[8] It would be anomalous indeed if a proxy could do what a court could not, unless the proxy were specifically authorized by the maker. To allow anything more would require an in-depth consideration of issues which are beyond the scope of this Report. We have issued a Discussion Paper on the subject[9] and, in due course, the responses to it will be considered and a final Report will be submitted to the Minister of Justice and Attorney General with our recommendations. In the meantime, for the reasons mentioned, we think that proxies should not be able to consent to these three procedures, unless the maker has specifically granted the power in the health care directive.

RECOMMENDATION 7

Unless specifically authorized in the health care directive, a consent by a health care proxy to inter vivos tissue donation, medical treatment for the primary purpose of research and non-therapeutic sterilization should have no effect.

Although the recommendation that the instructions contained in a health care directive and the appointment of a health care proxy take effect on the maker's loss of capacity to make health care decisions is simple enough, its potential complexities should not be overlooked. Sometimes, the determination of capacity will be easy to make; a patient in a coma clearly lacks capacity. However, in many cases these determinations will be extremely difficult, for competence is multi-faceted. An individual who is able to look after his or her own finances may nonetheless lack the capacity to make health care decisions. An individual may have the capacity to make some decisions about medical treatment, but not others. An individual may go in and out of periods of lucidity and, therefore, capacity; depending on his or her condition, the individual may have the capacity to make decisions about medical treatment one day, but not the next. In light of the consequences, great care will have to be taken by the attending physician in making these determinations. Ideally, a physician with specialized training in the area will be involved in difficult cases, as will experts from other relevant disciplines; these might include psychologists, ethicists, social workers, and lawyers.

2. The Health Care Directive: "As Effective As"

Once operative, the instructions contained in a health care directive or given by a health care proxy should be as effective as the instructions which could have been given by the maker while competent. At the same time, the limits which apply to the effectiveness of instructions given by competent persons about their current health care should apply equally to the effectiveness of instructions contained in health care directives and instructions given by health care proxies. As Robins J.A. stated in *Malette* v. *Shulman*:

> The state undoubtedly has a strong interest in protecting and preserving the lives and health of its citizens. There clearly are circumstances where this interest may override the individual's right to self-determination. For example, the state may in certain cases require that citizens submit to medical procedures in order to eliminate a health threat to the community or it may prohibit citizens from engaging in activities which are inherently dangerous to their lives.[10]

Euthanasia is an example of such a limit. A consent to the injection of poison will not be given effect, as the active taking of a life is not acceptable in our society; thus, a consent to euthanasia contained in a health care directive or given by a health care proxy should be similarly

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[8] *Re Eve* (1986), 31 D.L.R. (4th) 1 (S.C.C.).

[9] Manitoba Law Reform Commission, *Sterilization of Minors and Mentally Incompetent Adults* (1990, Discussion Paper).

[10] *Supra* n. 2, at 333.

inoperative. Another example can be found in the limits placed on mature minors.[11] Although mature minors can give or refuse consent to therapeutic procedures, their consent to non-therapeutic procedures is generally not effective. The same limitations should apply to their instructions in health care directives and to those given by their health care proxies.

In short, we propose that the effectiveness of instructions contained in a health care directive or given by a health care proxy be equated with the effectiveness of instructions which are given by the maker while competent. A corollary of this principle is that the consequences of non-compliance with instructions contained in a health care directive or given by a health care proxy should be the same as the consequences of non-compliance with current health care instructions: the civil law remedy of damages for battery, and professional discipline. This differs significantly from the approach taken in most American states. There, the law attempts to ensure compliance by physicians with the advance directives of patients by making non-compliance an offence punishable by a fine, a jail term or both. However, we think that this approach is unnecessary. Our consultations have indicated that physicians will appreciate a mechanism which facilitates communication with their patients and will follow a patient's clearly expressed advance wishes or the wishes of his or her proxy as readily as they now follow wishes concerning current care. We also think that such an approach would be counter-productive; the threat of imprisoning physicians will do little to promote the acceptance of this new method of medical decision-making. In any event, it would be inconsistent with our goal of extending the principles which govern the law of present medical consent to future medical consent.

In our view, therefore, the best way of ensuring that the instructions contained in a health care directive or the instructions of a health care proxy are followed is to equate them with the instructions which could have been given by the maker while competent. Those instructions would have the same force as instructions given by the maker; failure to follow those instructions would have the same consequences.

RECOMMENDATION 8

The consent or refusal to consent to future medical treatment set out in a health care directive and the consent or refusal to consent to medical treatment given by a health care proxy on the maker's behalf should be as effective as the consent or refusal by the maker would be if he or she had the capacity to make the health care decision.

RECOMMENDATION 9

A failure to follow the instructions in a health care directive or the instructions given by a health care proxy should have the same consequences as a failure to follow the instructions of the maker if he or she had the capacity to make the health care decision.

The result of our proposals would be that, after a person with a health care directive becomes incapable of giving instructions about medical treatment, such instructions would be taken from the health care directive or from the health care proxy appointed in the directive. Health care professionals would be required to look to those instructions and to follow them, just as they would the instructions of a competent patient.

The fact that instructions contained in a health care directive or given by a health care proxy will be given effect over those of the maker's family and friends may not always be to

[11]Mature minors are persons under the age of 18 who can understand the nature and consequences of proposed medical treatment.

their liking. The maker's family and friends may want to be involved in decisions concerning the person's medical care, especially where they disagree with the maker's instructions in the health care directive, the choice of health care proxy or the instructions given by the proxy. Disgruntled family and friends who resent being left out of the decision-making process may try to force health care proxies and health care professionals to take orders from them by threatening legal action. Although we realize that family and friends may have sincere concerns in such situations and we believe that, in many instances, the health care proxy may wish to consult with them, the essence of our proposal is the principle of self-determination. The wishes of the maker of a health care directive, whether expressed directly in the document or through the health care proxy in whom he or she has reposed trust, must have priority.

To assure this, persons acting under the authority of a health care directive or the instructions of a health care proxy must know that they need not fear lawsuits from persons who want to be making the decisions themselves. Health care proxies must have the same assurance.

RECOMMENDATION 10

No action should lie against any person by reason only of having acted, in good faith, in accordance with the terms of a health care directive or in accordance with a decision of a health care proxy that is not contrary to the terms of the health care directive.

RECOMMENDATION 11

No action should lie against a health care proxy by reason only of having acted, in good faith, in accordance with the authority conferred by the health care directive.

Of course, this is not meant in any way to limit the liability for negligence of any person, including health care professionals and facilities. They should be immune from liability for carrying out the instructions, but not for the manner in which they carry them out. For example, if a physician performs an operation as instructed in a health care directive, no liability should flow from the mere fact of having performed the operation; however, if the operation were performed in a negligent manner, the physician should clearly be held liable for that misconduct.

In extreme circumstances, unhappy relatives or friends may go to court in order to oust the health care proxy. At present, a court can, on application, appoint a committee to make decisions on a person's behalf. Although committees are generally given power only over the estate of the person, their authority can sometimes extend to decisions concerning the person's medical treatment. Alternatively, a court may, under its *parens patriae* jurisdiction, make health care decisions on behalf of persons who cannot care for themselves. The legitimate authority of a health care proxy would clearly be destroyed if a court could appoint a committee with the same powers or could displace a proxy's authority with its own, just because applicants or the court did not agree with decisions made by the proxy in good faith. We believe that a health care proxy must take precedence over a court-appointed committee and that a court should not exercise its *parens patriae* jurisdiction where a duly appointed health care proxy is willing and able to act.

We envision only one situation where this should not be the case: where the health care proxy is unable or unwilling to make a decision and no alternate proxy has been named. In such cases, we would not coerce proxies into making decisions; after all, some decisions, especially those carrying the risk of death for the maker, may prove exceedingly difficult to make. The threat of legal sanctions for failing to make a decision would be unreasonable and would only dissuade individuals from taking on the responsibility of acting as a health care proxy. In these

circumstances and only in these circumstances, a court-appointed committee should take precedence over a health care proxy and a court should be empowered to make necessary health care decisions.

RECOMMENDATION 12

Health care proxies should not be liable for failing to make a health care decision on behalf of the maker.

RECOMMENDATION 13

The health care decisions made by a health care proxy should have priority over the health care decisions made by a court-appointed committee. Similarly, a court should not exercise its parens patriae jurisdiction to make health care decisions for a maker where a duly appointed health care proxy is able and willing to act.

Where the health care proxy is able and willing to make health care decisions, the actions of a health care proxy should generally not be interfered with, even by a court. The health care proxy should be free to act in accordance with his or her own perception of the maker's best interests. After all, the maker has freely chosen the proxy to do just that. Only where it can be demonstrated that the health care proxy has breached the duty to act in good faith and in accordance with the wishes of the maker should it be possible to review his or her actions. In those limited circumstances, the court should be granted supervisory jurisdiction.

RECOMMENDATION 14

The health care decisions of a health care proxy should not be reviewable by a court unless it can be shown that he or she is acting in bad faith or contrary to the known wishes of the maker.

Where a court determines that a health care proxy has indeed acted in bad faith or has acted contrary to the known wishes of the maker, the court's remedies should generally be limited to rescinding the improper direction and suspending or revoking the appointment of the health care proxy. It should not be able to appoint a new health care proxy; only a maker should be able to confer the special powers and immunities which accompany that position. Instead, where more than one proxy has been named, the authority of any co-proxies should remain effective or the authority of any alternate proxy should come into effect upon the revocation or suspension. Only where the appointment of a health care proxy has been suspended or revoked and no other proxy has been named in the health care directive should the court be empowered to substitute its own decision for a rescinded decision.

RECOMMENDATION 15

Where it is shown that a health care proxy is acting in bad faith or contrary to the known wishes of the maker, a judge of the Court of Queen's Bench should be empowered to rescind a health care decision of the health care proxy and to suspend or revoke the appointment.

RECOMMENDATION 16

Where the court rescinds a health care decision of the health care proxy and no other health care proxy is appointed in the health care directive, the court should be empowered to substitute its decision for that of the rescinded decision.

D. RELATIONSHIP WITH THE COMMON LAW

As we indicated at the beginning of this Chapter, the common law does not generally recognize advance directions given in respect of future medical treatment. There are exceptions though. The "no blood" card found in Mrs. Malette's purse was held to be legally effective.[12]

The scheme which we propose in this Report would not affect these pre-existing rights in any way and would not impede the courts from expanding them. Instead, our scheme is intended to co-exist with the common law; the fact that an individual may not have made a health care directive in the prescribed manner would not, in the appropriate case, prevent the law from giving it effect in accordance with common law principles.

RECOMMENDATION 17

The rights and responsibilities conferred in the scheme proposed in this Report should be in addition to, and not in substitution for, any rights and responsibilities now or hereafter conferred by statute or common law.

[12]*Supra* n. 2.

CHAPTER 3

IMPLEMENTING HEALTH CARE DIRECTIVES

In this Chapter, we consider some of the more technical, but nonetheless important, issues surrounding the implementation of our proposed scheme giving effect to health care directives. These include requirements for their execution and revocation and the qualifications of makers and proxies.

A. EXECUTION

As we have observed on another occasion,[1] formalities of execution serve a number of important functions. They protect the maker from undue influence and fraud, they provide reliable and permanent evidence of the intentions of the maker, and they impress upon the maker the significant consequences of the document. We have borne these functions in mind in considering the method of execution which should be required of health care directives. However, we have also borne in mind that, to the limited extent that the common law presently recognizes advance directions, a signed written statement has been found to be adequate.[2] We believe that health care directives should be as accessible as possible to everyone who wishes to make one. Accordingly, the method of execution of health care directives should be as simple as possible, should involve formalities only to the extent that is absolutely necessary and should approximate as closely as possible the method which has been accepted at common law.

Because of the inherent lack of reliability associated with one person recalling another person's prior oral statements, oral health care directives should not be allowed under our scheme. In order to reduce problems of proof and fraud while still maintaining simplicity, we would only require that health care directives be in writing and signed by their makers. Although a witness might be desirable, it should not be required. The same opportunity to make a health care directive should be provided to persons who are physically unable to execute one by allowing a substitute to sign on behalf of the maker. To guard against the risk of fraud or forgery, we would adopt safeguards similar to those required for substitute execution of testamentary wills under *The Wills Act*. The substitute should sign the directive only at the direction of and in the presence of the maker and the maker should acknowledge the signature in the presence of a witness who would then attest the document. As a protection against undue influence, the health care proxy and his or her spouse should be barred from signing on behalf of the maker or acting as a witness to the substitute's signature.

RECOMMENDATION 18

A health care directive should be in writing.

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[1]Manitoba Law Reform Commission, *Report on 'The Wills Act' and the Doctrine of Substantial Compliance* (1980, Report #43) 14-17.

[2]*Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.).

RECOMMENDATION 19

A health care directive should be:

(a) signed by the maker; or

(b) signed by some other person at the direction of and in the presence of the maker and the maker should acknowledge the signature in the presence of a witness who attests the document.

RECOMMENDATION 20

Where the person who is appointed in the health care directive as health care proxy, or his or her spouse, signs the health care directive on behalf of the maker or witnesses its execution, the appointment should be void.

Not everyone who appoints a health care proxy will ask the intended proxy about his or her willingness to accept the responsibility. It would be unfortunate for the maker if the proxy was unwilling to assume this position and was notified of the appointment only after the maker had become incapable of executing a new health care directive and was therefore incapable of appointing another proxy. It would also be unfair to put the intended proxy in such a position; he or she may not want to assume the responsibility, but may feel obliged to do so where the maker cannot appoint someone else. To avoid this possibility, we think it important that the maker of a health care directive obtain the intended proxy's consent to the appointment. As an added benefit, such a requirement would likely promote discussion between the maker and the proxy about the maker's wishes for future medical care.

As proof of the consent, it should be in writing; if the proxy is unable to sign, another person should be permitted to do so on his or her behalf.

RECOMMENDATION 21

The appointment of a health care proxy should not be effective unless the proxy (or another person at the direction of the proxy) has signified his or her consent in writing prior to the maker ceasing to have the capacity to make health care decisions.

B. QUALIFICATIONS OF MAKER AND PROXY

In keeping with our philosophy of making health care directives as effective as directions given in respect of current treatment, only individuals who have the capacity to give or refuse consent to their current medical treatment should be permitted to execute a health care directive. The difficulty with this requirement is that it can create ambiguity. After all, in the absence of a prior determination of capacity, how could those who are asked to give effect to a health care directive be certain that its maker had the necessary capacity to execute it? This would be a particular problem where a health care directive has been executed by a minor.

The latter problem could be solved simply by setting an arbitrary age below which individuals would be barred from executing a health care directive. However, if the age chosen were not low enough, this would inevitably bar some mature minors with the necessary capacity from directing their future medical treatment. If the age chosen were too low, some minors who did not have the necessary capacity to direct their current medical treatment would nonetheless be allowed to direct their future medical treatment.

We prefer an approach which is more flexible and in keeping with our attempt to extend the rights of those who are already entitled to control their health care. Those who are asked to rely on health care directives should be able to make an assumption about individuals who have executed these documents: they should be able to assume that, in the absence of evidence to the contrary, an individual over a particular age has the capacity to execute a health care directive and an individual below that age lacks the requisite capacity. After examining other Manitoba statutes which set out age restrictions for consent to particular medical procedures, we have chosen the age of 16 as the threshold.[3] Health care professionals and proxies would be able to rely on a health care directive made by a person 16 years of age or older, but not on one which was executed by someone younger than 16. However, a health care directive made by a person below the age of 16 might still be given effect if there were adequate evidence indicating that the particular minor had the capacity to make medical treatment decisions when he or she executed the directive. Similarly, a health care directive made by a person 16 years of age or older might still be invalidated if sufficient evidence of lack of capacity were presented.

RECOMMENDATION 22

There should be a rebuttable presumption that a person who is 16 years of age or older has the capacity to make health care decisions and that a person who is younger than 16 years of age does not have the capacity to make health care decisions.

We would take a more absolute position with respect to minimum age requirements for persons acting as health care proxies. In our view, making decisions, perhaps life-and-death decisions, on behalf of another person differs greatly from making decisions about one's own health care and calls for a higher level of maturity. We would choose the age of majority.

RECOMMENDATION 23

Every health care proxy should be 18 years of age or older at the time of his or her consent to the appointment.

In our Discussion Paper, we referred to legislation in the United States which barred various classes of persons from acting as health care proxies because of fears that they might exercise influence over the maker or be otherwise untrustworthy. We would not bar any person from acting as a health care proxy merely because of his or her membership in a particular class. Such presumptions of untrustworthiness seem to us unfair and an unreasonable restraint on the discretion of the maker to appoint the individual in whom he or she has the greatest confidence.

C. MULTIPLE PROXIES

Makers may on occasion choose to appoint more than one person to act jointly, rather than successively, as health care proxies. Ideally, in those situations, the maker will also specify whether those persons must act unanimously or whether the decision of the majority of them will prevail; they will also specify what is to happen when one of the co-proxies dies or is unavailable. However, because makers will often omit to specify this in the health care directive, we believe that a statutory rule should be provided.

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[3]This choice would be consistent with the age chosen in *The Human Tissue Act*, C.C.S.M. c. H180, ss. 10(1), (2) and 11(1), below which very stringent requirements must be met for a minor to make an inter vivos tissue donation and above which, less stringent requirements are necessary. It would also be consistent with the age chosen in *The Family Maintenance Act*, C.C.S.M. c. F20, s. 21(2), below which parental consent is required for a blood test.

RECOMMENDATION 24

Where more than one health care proxy is named in a health care directive to act jointly rather than successively, the following rules should apply unless the health care directive provides otherwise:

(a) the decision of the majority shall be deemed to be the decision of all; and

(b) where one or more of them dies before or after the coming into effect of the health care directive or is unwilling or, after reasonable inquiries, unavailable to make a health care decision, the remainder of them may make the decision and the decision of the majority of the remainder shall be deemed to be the decision of all.

Makers may also neglect to indicate whether a number of named proxies are to act jointly or successively. We would also suggest a statutory rule to clarify this.

RECOMMENDATION 25

Where more than one health care proxy is named in a health care directive and it is unclear whether they are to act jointly or successively, it should be deemed that they are to act successively.

D. FORM OF HEALTH CARE DIRECTIVE

In some American states, only the form mandated by legislation is recognized for the expression of wishes concerning future medical treatment; other forms are considered to be invalid. In our view, such a rule is too inflexible and will inevitably result in health care directives being invalidated for mere technicalities. Individuals should be able to use any form and any words which clearly express their wishes for future medical treatment. However, it would be useful if forms were provided as guidance to individuals. In Appendix B, we set out two possible forms - one relatively simple, the other more complex but perhaps more meaningful - which might be considered as models. Over time and with greater experience, we are sure that improved forms will be devised.

RECOMMENDATION 26

Health care directives should be in any form which clearly expresses the intention of the maker. However, as an aid, suggested forms should be made available.

Of course, the difficulty with allowing individuals to use any form of health care directive and, indeed, the difficulty with allowing them to use a simple fill-in-the-blanks type of health care directive (such as Form B.1 in Appendix B) is that they may state their wishes in a manner which is not meaningful to health care professionals; for example, the maker may have used phrases such as "heroic measures". Such phrases "are open to multiple interpretations on when to act and on what interventions the patient would desire."[4]

> Left to their own efforts, many people will be unable to imagine, delineate, and articulate in precise terms the possible clinical circumstances and range of medical interventions in which an advance

[4]L.L. Emanuel and E.J. Emanuel, "The Medical Directive: A New Comprehensive Advance Care Document" (1989), 261 J.A.M.A. 3288 at 3289.

care document might be useful. Detailing for patients specific illness scenarios and treatment options ensures they have the opportunity to express their wishes as precisely as possible . . . .[5]

For these reasons, it will often be wise (although we would not require it) for the maker to involve a physician in the preparation and execution of a health care directive. Physicians could help persons to put their wishes for future medical treatment into words that will be clearly understood both by health care proxies and the health care professionals who will be asked to give effect to those wishes. Their assistance would allow individuals to make more sophisticated health care directives which go beyond simple but ambiguous terminology, such as "heroic measures", and which address specific treatment scenarios. More sophisticated health care directives would better promote our goal of self-determination and would benefit the health system as a whole. For this reason, consideration should be given to making the assistance of physicians in this regard a billable service under Medicare.[6]

E. REVOCATION

Individuals will change their minds about their wishes for future treatment and about their choice of a health care proxy. Clearly, this must be accommodated. Only if they can revoke and execute new directives will individuals feel comfortable about executing them in the first place.

In order to revoke a health care directive, an individual should have the capacity necessary to execute a new directive. This will ensure that only those individuals who understand the consequences of revocation will be allowed to revoke, and that individuals who revoke their directive will not be left without one because they cannot execute a new one.

RECOMMENDATION 27

A health care directive should be revocable by its maker while he or she has the capacity to make health care decisions.

Just as we emphasized simplicity in the execution of health care directives, it should also be simple for individuals to revoke them. All that we should require is that the individual clearly and reliably evidence an intention to revoke the health care directive. Accordingly, oral revocation should not be allowed, in order to avoid problems of proof.[7] We think that the rules for the revocation of wills in *The Wills Act* provide good, judicially interpreted guidelines for the revocation of health care directives and we would, therefore, adopt them.

RECOMMENDATION 28

A health care directive should be revocable by:

(a) a later health care directive;

(b) a later writing declaring an intention to revoke the health care directive and made in accordance with the provisions governing the making of health care directives; or

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[5] *Id.*, at 3291.

[6] *The Health Services Insurance Act*, C.C.S.M. c. H35.

[7] It is important to remember that there is a difference between a health care directive and an oral consent or refusal of consent given while competent. Consider this scenario. A person makes a health care directive stating that under no circumstances does she wish to undergo amputation. Some time later, she requires surgery. Moments before the surgery is to begin, she calls the surgeon over and states that, if it becomes necessary, she is prepared to undergo amputation. Such a statement is not a revocation of the health care directive. However, assuming the patient is competent, that statement is a valid consent to treatment which is recognized by the common law.

(c) burning, tearing or otherwise destroying all original executed copies of the health care directive by the maker or by some other person in the presence and by the direction of the maker with the intention of revoking it.

Another matter concerns the appointment of one's spouse as proxy and the subsequent termination of the marriage. We believe that most individuals would not want their ex-spouse to continue to be authorized to act as their health care proxy after their marriage to that spouse has been terminated and that not every person will think to revoke the appointment and appoint a new proxy in this circumstance. Automatic revocation of the appointment on divorce (or other termination) would ensure that ex-spouses would not be authorized to act as a health care proxy. Of course, should an individual wish to have his or her ex-spouse continue to hold the appointment, that individual could re-execute the directive after the event. It should be noted that we are recommending only that the appointment of an ex-spouse as proxy be revoked; the remainder of the health care directive would remain effective. This means that any instructions in the health care directive about future medical treatment would remain in effect, as would the appointment of other proxies.

RECOMMENDATION 29

Where the spouse of the maker is appointed as health care proxy and, after the making of the health care directive, the maker's marriage to that spouse is terminated, the appointment of the spouse should become void.

F. RENUNCIATION

Even though a health care proxy must consent to the appointment, we recognize that proxies may sometimes change their minds about accepting the position. If individuals were not allowed to change their minds, it would, no doubt, be more difficult to get individuals to agree to take on the responsibility of health care proxy. Therefore, to encourage persons to accept the responsibility, proxies should be allowed to renounce their authority at any time, even after their makers have become unable to execute other directives, and even when other proxies have not been named in the health care directives.

RECOMMENDATION 30

A health care proxy should be able to renounce the appointment at any time.

G. PRESUMPTION OF VALIDITY

The requirements which we propose for execution of a health care directive are quite simple and not at all onerous. However, health care professionals and facilities who are asked to follow a directive or the instructions of a proxy will want to be certain that even these minimal requirements have been met and that the directive or the appointment of the proxy has not been revoked or terminated. They should not have to enter into an investigation to confirm that the signature on the document is the true signature of the maker or that a more recent health care directive does not exist. They should also not have to be concerned that, despite their ability to rely on certain presumptions concerning the maker's capacity, it will subsequently be shown that the maker actually lacked the capacity to make the health care directive. A health care proxy should similarly not have to be concerned that the maker subsequently revoked his or her appointment or that the maker in fact lacked the capacity needed to make the appointment. So long as they act in good faith on the basis of a document which appears to be genuine, health

care proxies and health care professionals and facilities should be protected when the invalidity of the document is subsequently discovered.

RECOMMENDATION 31

A health care directive which has been acted upon and

(a) which is not properly executed; or

(b) which has been revoked; or

(c) which is made by a person who did not in fact have the capacity to make health care decisions

should be deemed to be valid if the person who acted upon it had no reason to believe that the health care directive was not in fact properly executed, was revoked, or was made by a person who lacked the necessary capacity.

H. RELEASE OF MAKER'S MEDICAL INFORMATION

Fundamental to the law respecting consent to medical treatment is the doctrine of informed consent. Every patient is entitled to be sufficiently informed to enable him or her to decide whether to submit to a proposed procedure or therapy; although every detail need not be discussed, the physician must "[answer] a patient's questions and [volunteer] . . . information of the nature, material risks and alternatives of the proposed treatment and of the consequences of inaction."[8]

Clearly, if the health care proxy is to be substituted as the maker's decision-maker, the proxy must also be substituted as the person entitled to obtain the information needed to give an informed consent. The health care proxy should have all necessary access to information concerning the maker's medical condition, the proposed course of action and any alternatives.

RECOMMENDATION 32

A health care proxy should have the right to receive all information concerning the maker's medical condition and proposed care which is needed to make informed health care decisions for the maker.

I. MISCELLANEOUS MATTERS

1. Onus on Maker

The maker's wishes in a health care directive can only be given effect if those who are responsible for administering medical treatment to the patient are aware of the directive's existence. Similarly, a health care proxy will only be consulted about medical treatment for the maker where health care professionals are aware of the proxy's appointment. We considered a number of methods by which the existence of a health care directive might be made known. We considered the possibility of establishing a central office in which all health care directives and revocations of health care directives would be registered, but concluded that it would be impractical, expensive and prone to being out of date or incomplete (for example, a revocation

[8] B. Sneiderman, J.C. Irvine and P.H. Osborne, *Canadian Medical Law* (1989) 49.

might not be filed in a timely fashion or at all). We also considered requiring health care professionals and health care facilities to inquire into whether a patient has made or revoked a health care directive, but decided against this also. Aside from the practical difficulties (some patients may arrive unconscious or in some other condition precluding communication), it seems to us more appropriate that the onus for publicizing the existence or revocation of a health care directive rest on the person who wishes it to be given effect: the maker. To this end, individuals should be encouraged to inform their families and physician about their health care directive (or its revocation) and to carry a copy on their person.

RECOMMENDATION 33

The onus should be on the maker to notify others of the existence or revocation of a health care directive and the appointment or revocation of the appointment of a health care proxy.

RECOMMENDATION 34

No action should lie against any person by reason only of having acted contrary to the wishes of a maker where the person did not know of the existence of the maker's health care directive or its revocation.

Although the onus of notification should be on the maker, it would nonetheless be beneficial for hospitals and other health care facilities to inquire about the existence of health care directives as part of their admission procedures and to establish a method of recording their findings. Certainly, this would be of great assistance to patients who are almost invariably treated within a facility by more than one health care professional.

2. No Presumption About the Maker's Wishes

In the Discussion Paper, we referred to legislation in the United States and Australia which provides individuals with a mechanism to refuse in advance life-prolonging medical treatment should they become terminally ill. In most of these jurisdictions, the legislation specifically provides that no presumption can be made about an individual's wishes for future medical treatment on the basis that the individual did not make a health care directive. The rationale for this is that the focus on refusal of treatment might lead others to assume that an individual who did not make a health care directive must necessarily want life-prolonging treatment to be administered in the event of a terminal illness.

However, under our proposed scheme, health care directives have a scope beyond refusal of treatment. Individuals would be free to consent or refuse consent to any medical treatment in their health care directive, in the same way that they can consent or refuse consent to current medical treatment while competent. Thus, unlike the jurisdictions referred to, there is no basis for anyone to make an assumption about an individual's wishes on the basis of any failure to make a health care directive.

Similarly, no inference should be drawn from the revocation of a health care directive. The fact that an individual has revoked a directive setting out a preferred course of treatment should not entitle anyone to assume that the individual must therefore want the opposite course. The individual may have revoked the health care directive for an entirely different reason.

RECOMMENDATION 35

No presumption about the health care wishes of a person should be made on the basis that the person did not execute or revoked a health care directive.

3. Benefit to Proxy

At common law, a person cannot benefit from his or her wrongdoing. This means, for example, that if a person murders his or her spouse and is named as the beneficiary under the spouse's will or insurance policy, he or she will not be allowed to receive these benefits because of the wrongdoing. It is possible that someone would suggest that the direction of a health care proxy to a physician to withdraw or not initiate life-prolonging treatment should be viewed in the same light; that is, it should be seen as a wrongdoing from which the proxy should not be allowed to benefit. However, this would be an entirely incorrect interpretation of the intent of health care directives and of the role of health care proxies. The actions of a proxy, done in good faith either in accordance with the maker's wishes or in accordance with what he or she considers to be the maker's best interests should not be considered as wrongdoing. The same considerations apply equally to persons who act as a substitute signer or a witness to the execution of a health care directive.

RECOMMENDATION 36

A health care proxy acting in good faith should not by reason only of so acting be precluded from inheriting from the maker or receiving the proceeds of an insurance policy on the life of the maker.

RECOMMENDATION 37

A person who signs a health care directive on behalf of the maker or a person who witnesses the substitute execution of a health care directive should not by reason only of having done so be precluded from inheriting from the maker or receiving the proceeds of an insurance policy on the life of the maker.

4. Penalties

The falsification, concealment, forgery or unauthorized destruction of another person's health care directive or revocation of a health care directive may have disastrous consequences for the maker. Those who participate in such activities should be punished. Although the *Criminal Code* provides adequate penalties for forgery, the offences relating to falsification and destruction of property apply only where the purpose was to defeat creditors. Similarly, although a penalty is prescribed for concealing one's own property with intent to defraud creditors, there is no penalty for concealing the property of another. For this reason, provincial legislation should provide a penalty specifically for such activities aimed at defeating the intentions of the maker. We would adopt the *Criminal Code* penalties for a summary conviction offence.[9]

RECOMMENDATION 38

Concealing, altering, forging, or destroying without authorization another person's health care directive or revocation of a health care directive should be an offence, punishable by a fine not exceeding $2,000.00 or up to six months imprisonment or both.

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[9]*Criminal Code*, R.S.C. 1985, c. C-46, s. 787(1), provides for the punishment applicable to summary conviction offences where no other punishment is specified in the Code.

5. Amendments to Existing Legislation

(a) *The Mental Health Act*

The Mental Health Act contains a few sections which provide for health care decisions to be made by others on behalf of mental health patients lacking that capacity. For example, it provides that, where the attending physician in a psychiatric facility believes that a patient is not mentally competent to consent to treatment, he or she must complete and file with the medical officer in charge a certificate to that effect with reasons for the opinion. The medical officer in charge must then send the certificate to the Public Trustee and, upon receiving or being notified of the certificate, the Public Trustee is empowered to consent to psychiatric or other medical treatment on behalf of the patient.[10] However, it seems to us that, where a mental health patient requires a substitute decision-maker, it is more appropriate that any health care proxy appointed by the patient play that role. The Public Trustee, after all, will generally be a stranger to the patient; the proxy will have been selected by him or her for the purpose. Similarly, where an application is made to a review board constituted under the Act or to a court to overturn a refusal by the Public Trustee to give consent, the Public Trustee must be made a party to the proceeding[11]; since we propose that any health care proxy should be the substitute decision-maker, the health care proxy should also be made a party to the proceedings.

RECOMMENDATION 39

The Mental Health Act should be amended to give a maker's health care proxy priority over the Public Trustee in the making of health care decisions and to make the health care proxy a party to all proceedings respecting those health care decisions.

The Mental Health Act also provides that clinical records are not to be disclosed to any person, except in specified circumstances and to specified persons.[12] If a health care proxy is to make informed decisions on behalf of the maker, restrictions on who can examine the maker's clinical records should be amended so that a person's health care proxy can also receive this information.

RECOMMENDATION 40

The Mental Health Act should be amended to permit a health care proxy to examine the clinical record of the maker.

However, *The Mental Health Act* poses a few other problems which are not as easily answered. For example, it provides:

> Medical treatment may be given without consent to any patient of a psychiatric facility who, in the opinion of a psychiatrist, is not mentally competent or is under 18 years of age if there is imminent and serious danger to the life, a limb or a vital organ of the patient requiring immediate medical treatment.[13]

A review board established under the Act may grant an order "authorizing the giving of specified psychiatric treatment and other related medical treatment to an involuntary patient where consent

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[10] *The Mental Health Act*, C.C.S.M. c. M110, ss. 24(4),(5) and (5.1).

[11] *The Mental Health Act*, C.C.S.M. c. M110, ss. 26.5(4) and 26.7(1).

[12] *The Mental Health Act*, C.C.S.M. c. M110, ss. 26.9(2), (3) and (4).

[13] *The Mental Health Act*, C.C.S.M. c. M110, s. 24(7).

has been refused."[14] After enactment of our proposals, these provisions would be at variance with our goal of allowing individuals to determine their future medical treatment with a health care directive. Unlike other persons with health care directives, individuals falling within these provisions of *The Mental Health Act* could be forced to receive unwanted medical treatment.

However, we recognize that there may be policy reasons peculiar to the mental health field which would justify subordinating the principle of self-determination to other principles. For example, it may be argued that it is necessary for the protection of the individual and the public to continue to allow a review board to override a refusal of consent to treatment. However, we believe that a decision as to whether these restrictions are justified is beyond the scope of this Report and make no comment on it. The matter is best left to the consideration of professionals in the area and of persons who would be affected.

(b) *The Human Tissue Act*

The Human Tissue Act permits individuals who are 18 or over to make a donation of tissue to be effective upon their death.[15] Minors who are 16 or 17 years old are also permitted to make a tissue donation but the consent of a parent or legal guardian is required.[16] Minors under the age of 16 cannot make a donation at all. Where an individual has not made a tissue donation, his or her nearest relative (as defined in the Act) is empowered to authorize a donation after death.[17] We recognize that a decision about tissue donation after death cannot be considered to be a health care decision. However, it seems to us that an individual who has entrusted his or her health care to a proxy would likely also prefer that the proxy be the person authorized to make a tissue donation after death. We think that *The Human Tissue Act* should reflect this likely intention. However, we would not make a similar amendment for minors. While persons under the age of 18 who were able to appoint health care proxies might have the same intention, they cannot authorize a tissue donation on their own. A health care proxy appointed by a minor ought not to have greater rights than the minor who appointed him or her.

RECOMMENDATION 41

The Human Tissue Act should be amended so that, in the absence of a contrary intention in the health care directive, a health care proxy appointed by a person 18 years of age or older will have priority over the maker's nearest relative for the purposes of authorizing a tissue donation after the maker's death.

Finally, physicians who participate in a determination of death are prohibited from participating in an organ transplantation from that patient.[18] This restriction avoids conflicts of interest between physicians and patients. For the same reason, we suggest that physicians who participate in the withdrawal or withholding of life-prolonging treatment under the authority of a health care directive or a health care proxy should also be prohibited from participating in an organ transplant from that individual.

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[14] *The Mental Health Act*, C.C.S.M. c. M110, s. 25(1).

[15] *The Human Tissue Act*, C.C.S.M. c. H180, s. 2(1).

[16] *The Human Tissue Act*, C.C.S.M. c. H180, s. 2(2). Consent of a parent or legal guardian is not required if they are unavailable.

[17] The nearest relative is authorized to make a tissue donation after the death of the person or where the person is incapable of making a direction about tissue donation and death is imminent and inevitable: *The Human Tissue Act*, C.C.S.M. c. H180, ss. 3(1), (3) and (4).

[18] *The Human Tissue Act*, C.C.S.M. c. H180, s. 8(3).

RECOMMENDATION 42

The Human Tissue Act should be amended to prohibit physicians who participate in the withdrawal or withholding of life-prolonging medical treatment pursuant to a health care directive or the instructions of a health care proxy from participating in an organ transplantation from that person.

(c) ***Criminal Code***

In our Discussion Paper, we pointed out that health care professionals could theoretically be criminally liable in certain circumstances for following a person's health care directive or the directions of his or her health care proxy. Concerns about the possibility of such liability should be cleared up by an amendment to the *Criminal Code*.[19] However, only the federal government has the constitutional jurisdiction to make laws in the realm of criminal law.

RECOMMENDATION 43

The provincial government should request that the federal government amend the Criminal Code to grant immunity from criminal liability to persons who, in good faith, follow the instructions contained in a health care directive or the instructions of a health care proxy.

Nonetheless, we consider the likelihood of criminal liability being incurred for following the directions in a health care directive or the directions of a health care proxy to be extremely remote. We do not believe it to be a serious impediment to the immediate implementation of our proposals.

J. IMPLEMENTATION

In order to give effect to our recommendations, it will be necessary to enact new legislation. To facilitate this and to better explain our proposals, we have prepared a draft statute. It is set out in Chapter 4 with commentary and is then restated without the commentary in Appendix A.

RECOMMENDATION 44

The recommendations contained in this Report should be implemented by enactment of a new statute similar to the draft Health Care Directives Act set out in Appendix A.

Legislation allowing for health care directives and the appointment of health care proxies has been anticipated for some time. Indeed, many individuals have already made documents containing their instructions for future treatment. These previously executed documents should be given effect provided that they comply with the Act's minimal requirements for execution.

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[19] *Criminal Code*, R.S.C. 1985, c. C-46. We note that a recently introduced private member's bill in Parliament would "protect a physician from criminal liability where the physician does not initiate or continue treatment at the request of the patient or where the physician does not prolong life, except at the patient's request. It would also protect a physician who administers pain killing treatment to a terminally ill patient even though the effect of that treatment will hasten death.": excerpt from Explanatory Note to Bill C-351, An Act to amend the Criminal Code, which was introduced by Mr. R.L. Wenman, M.P., and which received First Reading on March 27, 1991.

RECOMMENDATION 45

Health care directives executed before the effective date of The Health Care Directives Act should be given effect if they comply with the execution requirements of the Act.

Finally, we observe that the enactment of legislation is not the end but the beginning of the process. Health care directives will only be effective mechanisms if the public becomes familiar with their use and their benefits. To ensure this, an educational programme should follow the passage of legislation authorizing health care directives and should be continued on an on-going basis.

RECOMMENDATION 46

There should be an extensive introductory programme and then an on-going programme to educate the public on the availability and use of health care directives.

CHAPTER 4

THE HEALTH CARE DIRECTIVES ACT (ANNOTATED)

In this Chapter, we attempt to demonstrate how our proposals would work in practice. We set out a draft Health Care Directives Act, together with annotations explaining the intent and effect of each section. The Act is restated without annotations in Appendix A.

Draft Act	**Annotations**
WHEREAS Manitoba law recognizes the right of every competent person to consent, refuse to consent or withdraw consent to his or her health care;	*The preamble is intended to set out the basic philosophy that underlies the Act: the control which an individual has over his or her health care after losing competence should be as close as possible to the control which he or she would have had if still competent. The balance of the Act flows from this essential principle.*
AND WHEREAS this right should also be respected after individuals are no longer able to participate in their health care decisions;	
NOW THEREFORE HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Manitoba, enacts as follows:	
Definitions. **1** In this Act	
"court" means the Court of Queen's Bench;	
"health care decision" means a consent, refusal to consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for an individual's physical or mental health or personal care;	*The definition of health care decision is intended to be very broad in scope. It is intended to encompass not only decisions about medical care in the ordinary sense, but every type of care which would have been under the direction of a competent person. Thus, a health care decision is not restricted to a refusal of heroic measures, as is so often the case in other statutes; it may include a consent or refusal of life-prolonging treatment, palliative care,*

nutrition or hydration. It may also include a decision about admission to a medical treatment facility, including a mental health treatment facility, or a consent or refusal of bathing, grooming and other non-medical matters which pertain to the care of the person's physical and mental well-being.

"health care directive" means a document made in accordance with this Act, whether made within Manitoba or elsewhere, before or after the coming into force of this Act, in which the maker sets out health care decisions, or appoints a health care proxy, or both;

A health care directive must be made in accordance with the execution requirements set out in sections 4 and 5. Of course, the fact that an expression of wishes concerning medical treatment is not recognized under this Act does not necessarily mean that it will not be recognized by the common law. For example, an oral direction given by a patient immediately before surgery (which would not be recognized as a health care directive under this Act, since it was not in writing) would almost certainly be accepted as valid by the common law.

Documents which were made outside of Manitoba or before the Act came into force would also be recognized as health care directives so long as they conformed with the Act's execution requirements.

"health care proxy" means the person or persons 18 years of age or older appointed by the maker of a health care directive to make health care decisions on his or her behalf;

No restrictions are placed on who can be appointed as health care proxy as long as the proxy is an adult. We expect that the health care proxy will generally be a trusted family member or close friend.

The Act also places almost no limits on what health care decisions can be made by a proxy (see section 3). However, the maker is free to place limits on the authority of the health care proxy in the health care directive.

"maker" means a person who makes a health care directive.

Coming into effect of health care directive.
2 A health care directive and the authority of a health care proxy become effective when the maker ceases to have the capacity to make and communicate health care decisions and continue to be effective for the duration of the maker's incapacity.

Individuals have a right to make their own health care decisions as long as they have the capacity to make them and to communicate them. The Act does not affect this. However, once the maker loses this capacity, the directions set out in his or her health care directive take effect. To the extent that those directions are not relevant or are unclear, the authority of the health care proxy, if one is appointed, to make health care decisions on behalf of the maker also takes effect.

Where a person temporarily loses the capacity to make or communicate health care decisions, he or she will again be entitled to make his or her own health care decisions as soon as the capacity is regained.

Effect of health care decision by maker.
3(1) A health care decision contained in a health care directive shall be as effective as if made by the maker prior to the maker losing the capacity to make the health care decision.

Effect of health care decision by health care proxy.
3(2) Subject to any express limitations in the health care directive and to subsection (3), a health care decision made by a health care proxy on behalf of a maker shall be as effective as if made by the maker prior to the maker losing the capacity to make the health care decision.

These are the core provisions of the Act. They equate the effect of directions given in a health care directive or by a health care proxy to the effect of directions which could have been given by the maker before the incapacity. Thus, a refusal of treatment, even if it is life-saving treatment, must be respected in the same way and to the same extent that a refusal given while the maker was competent would have been respected. A person who administers treatment contrary to the refusal in the health care directive or from the health care proxy will be liable for damages for battery and, perhaps, to professional discipline, just as he or she would have been if the direction had been given by the maker while competent.

By the same token, the limitations on the effectiveness of a competent person's health care decisions will also apply to a person's consent or refusal of consent in a health care directive and to a health care proxy's consent or refusal of consent on the maker's behalf. For example, a person's consent in a health care directive to active steps to end his or her life will not be effective since a person cannot give such a consent while competent.

The application of these provisions to minors is particularly noteworthy. For example, the consent of a minor to an inter vivos transplantation of his or her tissue to another person is not effective on its own. Among other requirements, minors 16 years of age or older need parental consent; minors under the age of 16 require the consent of a parent and of a court. As a result, the consent of a minor in a health care directive or of a minor's proxy to such a transplantation could similarly not be given effect. However, upon the minor attaining the age of 18 (the age at which a minor gains the capacity to consent to a transplantation), the formerly ineffective consent would become effective. This change in the effectiveness of the consent in the health care directive arises because the effectiveness of a given direction is determined as of the moment the maker loses the capacity to make health care decisions, not as of the date of execution of the health care directive. However, the validity of the document as a whole is determined as of the date of its execution (see section 5).

Limitation on effect.

3(3) A consent by a health care proxy on behalf of a maker to:

(a) medical treatment for the primary purpose of research;

(b) sterilization that is not medically necessary for the protection of the health of the maker; and

(c) the removal of tissue from the maker's body while living for transplantation to another person or for purposes of medical education or medical research

shall have no effect unless the health care proxy is expressly authorized in the health care directive to give such a consent.

An individual will be able in a health care directive to authorize inter vivos donation of tissue, treatment whose primary purpose is research and non-therapeutic (contraceptive) sterilization. However, a health care proxy will not be able to consent to these procedures unless expressly authorized to do so in the health care directive.

Writing required.
4(1) A health care directive shall be in writing.

In order to make health care directives as simple and accessible as possible, the execution requirements are very minimal. Health care directives need only be in writing and be signed by the maker. Persons unable to sign for themselves are given the same opportunity to make a health care directive through the use of a substitute signer; however, a witness for the substitute signer is required as a safeguard against fraud and forgery.

Execution.
4(2) A health care directive shall be signed

(a) by the maker; or

(b) by some other person in the presence and by the direction of the maker, in which case

(i) the person signing shall not be the health care proxy or the spouse of the health care proxy;

(ii) the maker shall acknowledge the signature in the presence of a witness, who shall not be the health care proxy or the spouse of the health care proxy; and

(iii) the witness shall attest and subscribe the health care directive in the presence of the maker.

Consent of proxy.
4(3) The appointment of a health care proxy is valid only if the health care proxy, or another person at the direction of the health care proxy, consents to the appointment in writing prior to the maker's incapacity.

A person's appointment as a health care proxy ought not to come as a surprise, revealed to him or her only when a health care decision for the maker is required. This would place an unreasonable burden on those proxies who had not had the opportunity to have a frank discussion with the maker concerning his or her wishes. Similarly, makers should be alerted that their intended proxies are unwilling to accept the responsibility, so that someone else can be appointed. Accordingly, the Act requires that a proxy (or someone on the proxy's behalf) consent in writing to the appointment.

Capacity of maker.
5(1) Every person who has the capacity to make health care decisions may execute a health care directive.

Presumption as to capacity to execute.
5(2) For the purposes of this section, there shall, in the absence of evidence to the contrary, be a presumption

(a) that a health care directive was made immediately prior to the maker losing the capacity to make health care decisions;

(b) that a person who is 16 years of age or older has the capacity to make health care decisions; and

(c) that a person who is younger than 16 years of age does not have the capacity to make health care decisions.

The Act allows every person who can presently make health care decisions to make a health care directive. Since minors with the appropriate level of maturity have the legal capacity to make some health care decisions, those minors will similarly have the capacity to make health care directives. However, this introduces an element of uncertainty for health care providers. How do they know what the level of capacity of a given minor was when the document was made? How do they know that a given adult did not in fact lack the necessary capacity? Indeed, how do they know how old the maker was when the document was executed?

In some cases, the answers to these questions will be known. However, where they are not known, the Act allows health care providers to make certain presumptions. They may assume that every person aged 16 or more has the necessary capacity unless they have evidence to the contrary. They may assume that every person under 16 does not have the necessary capacity, unless, again, they have evidence to the contrary. Where a health care directive is undated and they cannot tell the age at which the maker executed it, they may assume that it was made just before the incapacity.

Of course, care must be taken to distinguish the capacity to make a health care directive (s. 5) and the effect of a direction in that health care directive (s. 3). For example, a minor (whether over or under 16) might be determined to have the capacity to make a health care directive (whether by operation of the presumption or by the presentation of evidence of capacity). However, because a minor's consent to some non-therapeutic procedures is not effective, his or her consent in a health care directive to such a procedure would not be given effect.

Revocation.

6(1) So long as the maker has the capacity to make health care decisions, a health care directive may be revoked by

(a) a later health care directive;

(b) a later writing declaring an intention to revoke the health care directive and made in accordance with subsection 4(2) of this Act; or

(c) burning, tearing or otherwise destroying all original executed copies of the health care directive by the maker or by some other person in the presence and by the direction of the maker with the intent to revoke.

Makers may revoke health care directives in one of three ways. They may make a new health care directive containing new and different provisions or a statement that the old one is revoked. They may write out and sign a simple declaration revoking the health care directive, without making a new one (persons who are physically unable to do this would use the substitute procedure set out in section 4(2)(b)). Finally, they may intentionally destroy (or have someone else destroy) the health care directive; where more than one copy was executed, every original executed copy must be destroyed in order to avoid any confusion.

Effect of divorce.

6(2) Unless the health care directive expressly provides otherwise, if, after executing a health care directive in which the spouse of the maker is appointed as health care proxy, the maker's marriage is terminated by a divorce decree or is found to be void or declared a nullity by a court in a proceeding to which the maker is a party, the appointment of the spouse as health care proxy is revoked.

Divorce revokes any appointment of the spouse as a health care proxy. However, the balance of the health care directive (which may include statements as to treatment which the maker does or does not wish) remains in full force and is unaffected by the divorce.

Of course, the maker is free to make a new health care directive, naming someone else as the health care proxy. For that matter, the maker would be free to re-appoint the divorced spouse.

Best interests of the maker.

7(1) A health care proxy shall act

(a) in accordance with the wishes expressed by the maker prior to the maker's incapacity if they are known to the health care proxy; and

(b) when the health care proxy has no knowledge of the maker's wishes, in accordance with what the health care proxy, in his or her sole discretion, believes to be in the best interests of the maker.

If the health care proxy is aware of the wishes of the maker (whether they were expressed in the health care directive or elsewhere), his or her primary obligation is to act in accordance with those wishes. However, there will be many instances where the maker has not expressed any wishes which relate to the situation at hand. In those cases, the health care proxy's obligation is to make decisions which he or she believes to be in the best interests of the maker. In deciding what is in the best interests of the maker, the health care proxy will likely consider the consequences of the various proposals for treatment, as well as the maker's religious or philosophical beliefs and values. However, the factors which the proxy considers and the weight to be given to each factor are matters within the sole discretion of the proxy. The health care proxy's determination of the maker's best interests may differ from the judgments

of others; however, the proxy's obligation is to follow his or her own judgment.

No delegation.
7(2) A health care proxy may not delegate the authority to make health care decisions.

The authority of a health care proxy derives from the appointment by the maker. The proxy has been appointed because the maker trusts the proxy to make his or her health care decisions. For this reason, the health care proxy cannot be allowed to delegate the authority to another.

More than one proxy.
7(3) Where more than one health care proxy is named in a health care directive and the health care directive does not indicate whether they are to act jointly or successively, they shall be deemed to be appointed to act successively, in the order named in the health care directive.

Ideally, a maker will appoint only one person at a time to act as health care proxy. However, we recognize that, in some cases, people will not want to narrow their choice to one person and may insist on appointing more than one person. Sometimes, the maker's intentions in doing so will be clear. For example, a maker might name "my spouse, A, or, if my spouse dies or is unable to act, my child, B"; clearly, the maker intends A and B to act successively. A maker might name "my parents, A and B"; here, it is clear that A and B are to act jointly. However, the maker's intentions will not always be clear. For example, the maker may simply list a number of names. In those cases, where the maker's intentions cannot be determined from an examination of the health care directive, the statute presumes that the proxies are to act successively.

Joint proxies.

7(4) Where more than one health care proxy is named in a health care directive to act jointly rather than successively, the following rules shall apply, unless the health care directive provides otherwise:

(a) the decision of the majority shall be deemed to be the decision of all; and

(b) where one or more of them dies before or after the coming into effect of the health care directive or is unwilling or, after reasonable inquiries, unavailable to make a health care decision, the remainder of them may make the decision and the decision of the majority of the remainder shall be deemed to be the decision of all.

Special problems arise when a maker names more than one proxy to act jointly. This section provides rules to deal with them.

These rules are based on three principles. First, majority rules. Thus, if two persons are named to act jointly, they must both agree; failure to do so means that there is no decision and a health care provider would be in the same position as if there were no proxy at all. If three persons are named to act jointly, a health care provider may proceed on the strength of the decision of two of them, even though the third dissents. Second, if one of the persons named to act jointly dies, the survivor or survivors may carry on. Third, if one of them cannot be located after reasonable attempts are made, the rest may carry on.

It should be noted that some of the problems dealt with in this subsection can equally arise where there is only one person named as health care provider. That person may die or may be unavailable. In those cases, it is as if the maker had no health care proxy at all.

Review of misconduct.

8 Where the court is satisfied that a health care proxy is acting in bad faith or contrary to the known wishes of the maker, it may, on application, by order, suspend or terminate the appointment of the health care proxy, in which case it may also rescind a health care decision made by the health care proxy and, if the health care directive does not appoint more than one health care proxy, substitute its own decision in place of the rescinded decision.

Considerable power may be delegated by the maker to the health care proxy. However, the maker will not be in a position to monitor the use of that power once it becomes effective. For that reason, we propose that the Court of Queen's Bench have supervisory jurisdiction over health care proxies.

However, this jurisdiction should be limited. The court should have no role so long as the proxy is following the known wishes of the maker or is acting in what the proxy genuinely believes to be the best interests of the maker. In particular, the court should not be able to substitute its views of what is in the maker's best interests nor the views of any other person.

The supervisory jurisdiction of the court should be invoked only where it can be shown that the health care proxy is acting contrary to the maker's expressed wishes or is acting in bad faith. In those circumstances, the court should be able to

suspend or terminate the proxy's appointment and then to rescind a decision of the proxy. If the maker had named more than one health care proxy in the health care directive, the remaining proxy or proxies would then be empowered to make a new decision in place of the rescinded one. Only where no other health care proxy is named would the court substitute its own health care decision.

Jurisdiction of court and committee.

9 Unless a health care directive provides otherwise, a health care decision made by a health care proxy on behalf of a maker shall have priority over a health care decision made by a court or by any other person, including a committee appointed by the court pursuant to The Mental Health Act or The Court of Queen's Bench Act.

This section is intended to reinforce the restricted nature of the court's supervisory jurisdiction over health care proxies.

Although it is not often done, it is theoretically possible for a court to appoint a committee with authority to make health care decisions for an incompetent individual. A court may also make health care decisions itself on behalf of an incompetent individual under its parens patriae jurisdiction. Thus, persons who are unhappy with the decisions of a health care proxy might ask a court to exercise its jurisdiction and make its own decisions on behalf of the incompetent individual or might seek the appointment of a committee in order to displace the health care proxy. This section aims to prevent this. It provides that a decision made by a health care proxy will have priority over one made by a court-appointed committee and even over one made by a court.

This, of course, does not prevent a court from dealing with the misconduct of a health care proxy. The procedure for this is set out in section 8.

Instructions to counsel.

10 In any proceeding in which the capacity of a maker to make health care decisions is at issue, the maker shall be deemed to have capacity to instruct counsel.

As indicated in section 2, a health care directive comes into effect when the maker ceases to have capacity to make his or her own health care decisions. Often, it will be quite clear when the maker lacks this capacity. However, there may be some instances where the issue is in dispute and a court is asked to resolve it.

In those cases, the maker should be able to be represented by a lawyer, if he or she chooses. However, a lawyer representing

such a maker is placed in a difficult position. A lawyer can only accept instructions from a competent client, yet the very issue at stake is the client's competence. This section protects the maker by ensuring that he or she can receive legal representation.

No onus of inquiry.

11 No person shall be required to inquire as to the existence of a health care directive or any revocation thereof.

The onus is on the maker to let others know about the existence or revocation of his or her health care directive. No one else is under any obligation to check. As a result, no one is liable for failing to act in accordance with a health care directive if he or she did not know of its existence.

Protection from liability.

12(1) No action lies against any person by reason only of

(a) having acted, in good faith, in accordance with the wishes expressed in a health care directive or in accordance with a decision of a health care proxy that is not contrary to the wishes expressed in a health care directive; or

(b) having acted contrary to the wishes expressed in a health care directive where the person did not know of the existence of the health care directive.

Section 12 is meant to protect all persons who, in good faith, act in accordance with a health care directive.

Subsection 12(1) allows a person who is asked to give effect to the instructions in a health care directive or the instructions of a health care proxy to do so without hesitation, even where relatives and friends of the maker of the document are opposed to those instructions, so long as the person acts in good faith and not contrary to the terms of the directive. If the person has reason to suspect, for example, that the health care directive was forged, he or she would not be protected from liability for going ahead and following it. Likewise, if the person knew that the maker's true intent was to commit suicide by refusing life-prolonging treatment, he or she would not be protected from liability for following those instructions.

The subsection also reinforces section 11 by specifically indicating that a failure to follow the instructions in a health care directive does not give rise to liability when the existence of those instructions is not known.

The protection from liability, however, does not preclude a person from being liable for damages for the negligent administration of health care to the maker.

Presumption of validity.
12(2) A health care directive which has been acted upon and

(a) which is not executed in accordance with this Act; or

(b) which has been revoked; or

(c) which is made by a person who did not have the capacity to make health care decisions

is deemed to be valid for the purposes of this Act if the person who acted upon it had no reason to believe that the health care directive was not in fact executed in accordance with this Act, was revoked or was made by a person who did not have the capacity to make health care decisions.

Subsection 12(2) protects persons who act under the authority of a health care directive which they believe to be valid which is subsequently found to be invalid. The subsection deals with three particular ways in which the health care directive might be found invalid:

a) There may be a flaw in the execution process. For example, a maker may have another person sign on his or her behalf. This is permitted, so long as a witness also signs (s. 4(2)(b)). If the substitute signs the maker's name but there is no witness, the health care directive will not be valid. However, a health care provider might reasonably believe that the maker had signed his or her own name and be unaware of the substitute signer's participation. In order to protect the health care provider, the document is deemed to be valid until he or she learns of the flaw in execution.

b) The health care directive may have been revoked. If someone acts on the authority of the health care directive without knowing this, his or her actions are validated.

c) The maker may have lacked the capacity to make the health care directive. Under subsection 5(2), persons are entitled to make certain presumptions about a maker's capacity. However, what if a presumption as to capacity is made which is subsequently found to be incorrect? This section would validate the acts done in good faith on the strength of the presumption.

Protection from liability for health care proxy.
12(3) No action lies against any health care proxy

(a) by reason only of having acted, in good faith, in accordance with the authority conferred by the health care directive; or

(b) for failing to make health care decisions on behalf of the maker.

Subsection 12(3) protects the health care proxy who acts in good faith. Since the proxy is being asked to make decisions based on what he or she believes to be in the maker's best interests, it is especially important to protect him or her from legal attack by those who hold contrary views.

Health care proxies may sometimes find themselves simply unable to make a

decision. They should not be forced to; this subsection absolves them from this failure.

Gift to witness, health care proxy, or person signing for maker.

13 Where a person or his or her then spouse is given or made a beneficial devise, bequest, or other disposition or appointment of or affecting real or personal property under the maker's will, or is named or whose then spouse is named as the beneficiary in the maker's life insurance policy, the devise, bequest, disposition or appointment and the receipt of proceeds of the insurance policy is not void by reason only that the person

(a) is a witness to the execution of the health care directive;

(b) is the health care proxy of the maker; or

(c) signs the health care directive on behalf of the maker.

At common law, a person cannot benefit from his or her wrongdoing. Thus, a beneficiary of an insurance policy cannot receive the policy's proceeds where he or she murders the insured.

Where a health care directive directs or a health care proxy authorizes a life-shortening procedure (such as the administration of certain pain-killing drugs), it might be argued that the health care proxy or persons associated with the execution of the health care directive had participated in "wrongdoing", simply because of that association. This would be an improper inference and the Act therefore bars it.

Of course, it does not bar such a conclusion where one of the parties truly does engage in some wrongdoing. It merely provides that the mere fact of being a witness or substitute signer or being a health care proxy is not "wrongful".

Release of medical information.

14 Notwithstanding any restriction, whether statutory or otherwise, relating to the disclosure of confidential medical information, but subject to any express limitations in the health care directive, a health care proxy shall have the right to be provided with all information necessary to make informed health care decisions on behalf of the maker.

The health care proxy requires access to the maker's medical information in order to make informed decisions for the maker. Although the maker could consent to the release of medical information in the health care directive, most makers will not think to do so. This section ensures that every proxy has the necessary access.

Existing rights.

15 Nothing in this Act abrogates or derogates from any rights or responsibilities now or hereafter conferred by statute or common law.

The intention of the Act is to create new rights, without altering other rights. The Act gives effect to a new instrument for giving consent or refusal to medical treatment, the health care directive. However, this section is meant to ensure that any other methods now recognized for giving consent or refusal will continue to be recognized. It also leaves the door open for the law to develop and recognize further mechanisms.

No presumption.

16 No inference or presumption shall arise by reason only that a person has not executed or has revoked a health care directive.

This section is intended to deal with situations such as the following:

a) An individual indicates an intention to make a health care directive stating a refusal to a specific procedure, but in fact never makes the directive. Can an assumption be made that the individual had a change of heart and would now consent to the procedure?

b) An individual makes a health care directive stating a consent to a specific procedure. Subsequently, the health care directive is revoked. Can an assumption be made that the individual would now refuse the procedure?

In each case, this section prevents such assumptions from being made. There may be many reasons why people may choose to make, not make or revoke a health care directive. It would be unreasonable to draw an inference in the absence of more concrete evidence.

A provision such as this is also often seen in American statutes. However, it must be remembered that the provision would have a very different meaning there. In many American states, these documents can be used only to refuse life-prolonging treatment. Accordingly, these provisions are intended to bar an inference that failure to execute a directive means that the person insists on all heroic measures. Since our statute has a broader ambit (it can be used to give consent or refusal to any treatment), such an inference can never be drawn.

Offence and penalty.

17 Any person who, without the maker's consent, wilfully conceals, cancels, obliterates, damages, alters, falsifies or forges a health care directive or a revocation of a health care directive is guilty of an offence and liable on summary conviction to a fine of not more than $2,000.00 or to imprisonment for a term of not more than six months or to both.

The purpose of this section is to provide the maker with protection to supplement that found in the Criminal Code from persons who would seek to interfere wrongfully with a health care directive.

Regulations.
18 The Lieutenant Governor in Council may make regulations prescribing a form for health care directives but the use of such form shall not be mandatory.

It is intended that sample forms of health care directives be published from time to time as a guide to potential makers. Their use would be entirely voluntary.

We include two possible samples in Appendix B. Over time, it is anticipated that these forms would be improved upon and the regulations updated.

Reference in Continuing Consolidation.
19 This Act may be referred to as chapter H27 of the Continuing Consolidation of the Statutes of Manitoba.

Technical provision.

Commencement of Act.
20 This Act comes into force on proclamation.

This Act introduces many new concepts. It creates new rights and responsibilities and requires that certain formalities be followed. The public will need time to become acquainted with its provisions. In order to allow time to mount an introductory education campaign, the Act does not come into force until a date in the future selected by the provincial government.

CHAPTER 5

CONCLUSION AND SUMMARY OF RECOMMENDATIONS

A. CONCLUSION

The implementation of any new scheme inevitably involves many small but important issues which must be resolved. This accounts for the rather large number of recommendations contained in this Report. However, our proposal really comes down to a few central concepts. Individuals should be free to make health care directives in which they can set out their wishes respecting future health care and can appoint health care proxies to make future decisions on their behalf. The decisions contained in health care directives or made by health care proxies should be legally binding; the failure to respect them should have the same consequences as the failure to respect a direction concerning current medical treatment. No one should incur liability simply because they honestly gave or followed such a decision. Finally, the making of health care directives should entail only as much formality as is manifestly necessary to protect the maker from fraud and undue influence.

The introduction of our scheme should result in benefits to both patients and health care professionals. Patients would gain increased control over their lives and their health care. Health care professionals would be given a safe and reliable method of learning their patients' wishes and, where a health care proxy is appointed, a substitute decision-maker with legal authority to take the place of informal but problematic consultations with family members. It would add some clarity to an area of the law in flux.

Persons considering the use of a health care directive should not, of course, overlook its possible drawbacks. Personal circumstances and medical technology change and a direction given today may not reflect a maker's wishes ten or twenty years later; a maker who fails to review and update a health care directive may face very serious and unwanted consequences indeed. A vague or imprecise health care directive may also pose problems; the making of a health care directive that refuses "heroic treatment" may give psychological comfort to a maker, yet prove meaningless to physicians. Makers must be made aware that they should avoid ambiguous language in their health care directives and that the assistance of a physician in making one may be helpful; where precision is not possible, the appointment of a health care proxy should be seriously considered.

Nonetheless, despite these words of caution, we believe that, for many people, the health care directive will be an appropriate, effective and welcome innovation for the expression of health care wishes.

B. SUMMARY OF RECOMMENDATIONS

The following is a summary of the recommendations contained in this Report.

1. The law should be reformed to permit the creation of a mechanism which would give legally binding effect to the wishes of a person, not now competent to make decisions about medical treatment, which were expressed when he or she had the capacity to make health care decisions. (p. 4)

2. The health care directive should be recognized as a mechanism to give legal effect to the expression of future health care wishes. (p. 5)

3. Every person who has the capacity to make health care decisions should be permitted to make a health care directive. (p. 5)

4. The health care directive should be a document in which the maker can:

   (a) give or refuse consent to future medical treatment; and/or

   (b) appoint one or more persons (a health care proxy) to make health care decisions on his or her behalf after he or she no longer has the capacity to make those decisions. (p. 5)

5. Upon the maker ceasing to have the capacity to make and communicate health care decisions and for so long as the maker lacks this capacity, the instructions contained in the health care directive should be given legal effect and, where there are no relevant instructions in the health care directive or those instructions are unclear, the instructions of the health care proxy, if any, should be given legal effect. (p. 6)

6. A health care proxy should act in accordance with the maker's wishes, if they are known, and in accordance with what he or she considers to be in the best interests of the maker if the maker's wishes are not known. The determination of the maker's best interests should be in the sole discretion of the health care proxy. (p. 6)

7. Unless specifically authorized in the health care directive, a consent by a health care proxy to *inter vivos* tissue donation, medical treatment for the primary purpose of research and non-therapeutic sterilization should have no effect. (p. 7)

8. The consent or refusal to consent to future medical treatment set out in a health care directive and the consent or refusal to consent to medical treatment given by a health care proxy on the maker's behalf should be as effective as the consent or refusal by the maker would be if he or she had the capacity to make the health care decision. (p. 8)

9. A failure to follow the instructions in a health care directive or the instructions given by a health care proxy should have the same consequences as a failure to follow the instructions of the maker if he or she had the capacity to make the health care decision. (p. 8)

10. No action should lie against any person by reason only of having acted, in good faith, in accordance with the terms of a health care directive or in accordance with a decision of a health care proxy that is not contrary to the terms of the health care directive. (p. 9)

11. No action should lie against a health care proxy by reason only of having acted, in good faith, in accordance with the authority conferred by the health care directive. (p. 9)

12. Health care proxies should not be liable for failing to make a health care decision on behalf of the maker. (p. 10)

13. The health care decisions made by a health care proxy should have priority over the health care decisions made by a court-appointed committee. Similarly, a court should not exercise its *parens patriae* jurisdiction to make health care decisions for a maker where a duly appointed health care proxy is able and willing to act. (p. 10)

14. The health care decisions of a health care proxy should not be reviewable by a court unless it can be shown that he or she is acting in bad faith or contrary to the known wishes of the maker. (p. 10)

15. Where it is shown that a health care proxy is acting in bad faith or contrary to the known wishes of the maker, a judge of the Court of Queen's Bench should be empowered to rescind a health care decision of the health care proxy and to suspend or revoke the appointment. (p. 10)

16. Where the court rescinds a health care decision of the health care proxy and no other health care proxy is appointed in the health care directive, the court should be empowered to substitute its decision for that of the rescinded decision. (p. 10)

17. The rights and responsibilities conferred in the scheme proposed in this Report should be in addition to, and not in substitution for, any rights and responsibilities now or hereafter conferred by statute or common law. (p. 11)

18. A health care directive should be in writing. (p. 12)

19. A health care directive should be:

    (a) signed by the maker; or

    (b) signed by some other person at the direction of and in the presence of the maker and the maker should acknowledge the signature in the presence of a witness who attests the document. (p. 13)

20. Where the person who is appointed in the health care directive as health care proxy, or his or her spouse, signs the health care directive on behalf of the maker or witnesses its execution, the appointment should be void. (p. 13)

21. The appointment of a health care proxy should not be effective unless the proxy (or another person at the direction of the proxy) has signified his or her consent in writing prior to the maker ceasing to have the capacity to make health care decisions. (p. 13)

22. There should be a rebuttable presumption that a person who is 16 years of age or older has the capacity to make health care decisions and that a person who is younger than 16 years of age does not have the capacity to make health care decisions. (p. 14)

23. Every health care proxy should be 18 years of age or older at the time of his or her consent to the appointment. (p. 14)

24. Where more than one health care proxy is named in a health care directive to act jointly rather than successively, the following rules should apply unless the health care directive provides otherwise:

    (a) the decision of the majority shall be deemed to be the decision of all; and

    (b) where one or more of them dies before or after the coming into effect of the health care directive or is unwilling or, after reasonable inquiries, unavailable to make a health care decision, the remainder of them may make the decision and the decision of the majority of the remainder shall be deemed to be the decision of all. (p. 15)

25. Where more than one health care proxy is named in a health care directive and it is unclear whether they are to act jointly or successively, it should be deemed that they are to act successively. (p. 15)

26. Health care directives should be in any form which clearly expresses the intention of the maker. However, as an aid, suggested forms should be made available. (p. 15)

27. A health care directive should be revocable by its maker while he or she has the capacity to make health care decisions. (p. 16)

28. A health care directive should be revocable by:

    (a) a later health care directive;

    (b) a later writing declaring an intention to revoke the health care directive and made in accordance with the provisions governing the making of health care directives; or

    (c) burning, tearing or otherwise destroying all original executed copies of the health care directive by the maker or by some other person in the presence and by the direction of the maker with the intention of revoking it. (pp. 16-17)

29. Where the spouse of the maker is appointed as health care proxy and, after the making of the health care directive, the maker's marriage to that spouse is terminated, the appointment of the spouse should become void. (p. 17)

30. A health care proxy should be able to renounce the appointment at any time. (p. 17)

31. A health care directive which has been acted upon and

    (a) which is not properly executed; or

    (b) which has been revoked; or

    (c) which is made by a person who did not in fact have the capacity to make health care decisions

    should be deemed to be valid if the person who acted upon it had no reason to believe that the health care directive was not in fact properly executed, was revoked, or was made by a person who lacked the necessary capacity. (p. 18)

32. A health care proxy should have the right to receive all information concerning the maker's medical condition and proposed care which is needed to make informed health care decisions for the maker. (p. 18)

33. The onus should be on the maker to notify others of the existence or revocation of a health care directive and the appointment or revocation of the appointment of a health care proxy. (p. 19)

34. No action should lie against any person by reason only of having acted contrary to the wishes of a maker where the person did not know of the existence of the maker's health care directive or its revocation. (p. 19)

35. No presumption about the health care wishes of a person should be made on the basis that the person did not execute or revoked a health care directive. (p. 19)

36. A health care proxy acting in good faith should not by reason only of so acting be precluded from inheriting from the maker or receiving the proceeds of an insurance policy on the life of the maker. (p. 20)

37. A person who signs a health care directive on behalf of the maker or a person who witnesses the substitute execution of a health care directive should not by reason only of having done so be precluded from inheriting from the maker or receiving the proceeds of an insurance policy on the life of the maker. (p. 20)

38. Concealing, altering, forging, or destroying without authorization another person's health care directive or revocation of a health care directive should be an offence, punishable by a fine not exceeding $2,000.00 or up to six months imprisonment or both. (p. 20)

39. *The Mental Health Act* should be amended to give a maker's health care proxy priority over the Public Trustee in the making of health care decisions and to make the health care proxy a party to all proceedings respecting those health care decisions. (p. 21)

40. *The Mental Health Act* should be amended to permit a health care proxy to examine the clinical record of the maker. (p. 21)

41. *The Human Tissue Act* should be amended so that, in the absence of a contrary intention in the health care directive, a health care proxy appointed by a person 18 years of age or older will have priority over the maker's nearest relative for the purposes of authorizing a tissue donation after the maker's death. (p. 22)

42. *The Human Tissue Act* should be amended to prohibit physicians who participate in the withdrawal or withholding of life-prolonging medical treatment pursuant to a health care directive or the instructions of a health care proxy from participating in an organ transplantation from that person. (p. 23)

43. The provincial government should request that the federal government amend the *Criminal Code* to grant immunity from criminal liability to persons who, in good faith, follow the instructions contained in a health care directive or the instructions of a health care proxy. (p. 23)

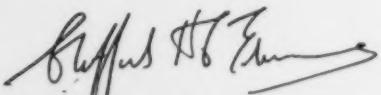
44. The recommendations contained in this Report should be implemented by enactment of a new statute similar to the draft Health Care Directives Act set out in Appendix A. (p. 23)

45. Health care directives executed before the effective date of The Health Care Directives Act should be given effect if they comply with the execution requirements of the Act. (p. 24)

46. There should be an extensive introductory programme and then an on-going programme to educate the public on the availability and use of health care directives. (p. 24)

These recommendations should be read in conjunction with our draft Act set out in Appendix A and explained in Chapter 4.

This is a Report pursuant to section 15(1) of *The Law Reform Commission Act*, C.C.S.M. c. L95, signed this 25th day of June 1991.



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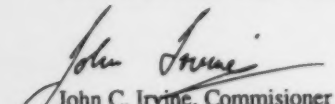

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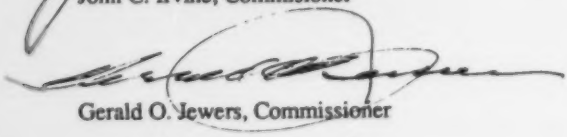

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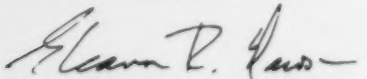
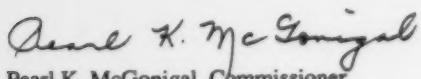


Eleanor R. Dawson, Commissioner



Pearl K. McGonigal, Commissioner

APPENDIX A

THE HEALTH CARE DIRECTIVES ACT

WHEREAS Manitoba law recognizes the right of every competent person to consent, refuse to consent or withdraw consent to his or her health care;

AND WHEREAS this right should also be respected after individuals are no longer able to participate in their health care decisions;

NOW THEREFORE HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Manitoba, enacts as follows:

Definitions.
1 In this Act

"court" means the Court of Queen's Bench;

"health care decision" means a consent, refusal to consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for an individual's physical or mental health or personal care;

"health care directive" means a document made in accordance with this Act, whether made within Manitoba or elsewhere, before or after the coming into force of this Act, in which the maker sets out health care decisions, or appoints a health care proxy, or both;

"health care proxy" means the person or persons 18 years of age or older appointed by the maker of a health care directive to make health care decisions on his or her behalf;

"maker" means a person who makes a health care directive.

Coming into effect of health care directive.
2 A health care directive and the authority of a health care proxy become effective when the maker ceases to have the capacity to make and communicate health care decisions and continue to be effective for the duration of the maker's incapacity.

Effect of health care decision by maker.
3(1) A health care decision contained in a health care directive shall be as effective as if made by the maker prior to the maker losing the capacity to make the health care decision.

Effect of health care decision by health care proxy.
3(2) Subject to any express limitations in the health care directive and to subsection (3), a health care decision made by a health care proxy on behalf of a maker shall be as effective as if made by the maker prior to the maker losing the capacity to make the health care decision.

Limitation on effect.
3(3) A consent by a health care proxy on behalf of a maker to

(a) medical treatment for the primary purpose of research;

(b) sterilization that is not medically necessary for the protection of the health of the maker; and

(c) the removal of tissue from the maker's body while living for transplantation to another person or for purposes of medical education or medical research

shall have no effect unless the health care proxy is expressly authorized in the health care directive to give such a consent.

Writing required.
4(1) A health care directive shall be in writing.

Execution.
4(2) A health care directive shall be signed

(a) by the maker; or

(b) by some other person in the presence and by the direction of the maker, in which case

(i) the person signing shall not be the health care proxy or the spouse of the health care proxy;

(ii) the maker shall acknowledge the signature in the presence of a witness, who shall not be the health care proxy or the spouse of the health care proxy; and

(iii) the witness shall attest and subscribe the health care directive in the presence of the maker.

Consent of proxy.
4(3) The appointment of a health care proxy is valid only if the health care proxy, or another person at the direction of the health care proxy, consents to the appointment in writing prior to the maker's incapacity.

Capacity of maker.
5(1) Every person who has the capacity to make health care decisions may execute a health care directive.

Presumption as to capacity to execute.
5(2) For the purposes of this section, there shall, in the absence of evidence to the contrary, be a presumption

(a) that a health care directive was made immediately prior to the maker losing the capacity to make health care decisions;

(b) that a person who is 16 years of age or older has the capacity to make health care decisions; and

(c) that a person who is younger than 16 years of age does not have the capacity to make health care decisions.

Revocation.
6(1) So long as the maker has the capacity to make health care decisions, a health care directive may be revoked by

(a) a later health care directive;

(b) a later writing declaring an intention to revoke the health care directive and made in accordance with subsection 4(2) of this Act; or

(c) burning, tearing or otherwise destroying all original executed copies of the health care directive by the maker or by some other person in the presence and by the direction of the maker with the intent to revoke.

Effect of divorce.
6(2) Unless the health care directive expressly provides otherwise, if, after executing a health care directive in which the spouse of the maker is appointed as health care proxy, the maker's marriage is terminated by a divorce decree or is found to be void or declared a nullity by a court in a proceeding to which the maker is a party, the appointment of the spouse as health care proxy is revoked.

Best interests of the maker.
7(1) A health care proxy shall act

(a) in accordance with the wishes expressed by the maker prior to the maker's incapacity if they are known to the health care proxy; and

(b) when the health care proxy has no knowledge of the maker's wishes, in accordance with what the health care proxy, in his or her sole discretion, believes to be in the best interests of the maker.

No delegation.
7(2) A health care proxy may not delegate the authority to make health care decisions.

More than one proxy.
7(3) Where more than one health care proxy is named in a health care directive and the health care directive does not indicate whether they are to act jointly or successively, they shall be deemed to be appointed to act successively, in the order named in the health care directive.

Joint proxies.
7(4) Where more than one health care proxy is named in a health care directive to act jointly rather than successively, the following rules shall apply, unless the health care directive provides otherwise:

(a) the decision of the majority shall be deemed to be the decision of all; and

(b) where one or more of them dies before or after the coming into effect of the health care directive or is unwilling or, after reasonable inquiries, unavailable to make a health care decision, the remainder of them may make the decision and the decision of the majority of the remainder shall be deemed to be the decision of all.

Review of misconduct.
8 Where the court is satisfied that a health care proxy is acting in bad faith or contrary to the known wishes of the maker, it may, on application, by order, suspend or terminate the appointment of the health care proxy, in which case it may also rescind a health care decision made by the health care proxy and, if the health care directive does not appoint more than one health care proxy, substitute its own decision in place of the rescinded decision.

Jurisdiction of court and committee.
9 Unless a health care directive provides otherwise, a health care decision made by a health care proxy on behalf of a maker shall have priority over a health care decision made by a court or by any other person, including a committee appointed by the court pursuant to The Mental Health Act or The Court of Queen's Bench Act.

Instructions to counsel.
10 In any proceeding in which the capacity of a maker to make health care decisions is at issue, the maker shall be deemed to have capacity to instruct counsel.

No onus of inquiry.
11 No person shall be required to inquire as to the existence of a health care directive or any revocation thereof.

Protection from liability.

12(1) No action lies against any person by reason only of

(a) having acted, in good faith, in accordance with the wishes expressed in a health care directive or in accordance with a decision of a health care proxy that is not contrary to the wishes expressed in a health care directive; or

(b) having acted contrary to the wishes expressed in a health care directive where the person did not know of the existence of the health care directive.

Presumption of validity.

12(2) A health care directive which has been acted upon and

(a) which is not executed in accordance with this Act; or

(b) which has been revoked; or

(c) which is made by a person who did not have the capacity to make health care decisions

is deemed to be valid for the purposes of this Act if the person who acted upon it had no reason to believe that the health care directive was not in fact executed in accordance with this Act, was revoked or was made by a person who did not have the capacity to make health care decisions.

Protection from liability for health care proxy.

12(3) No action lies against any health care proxy

(a) by reason only of having acted, in good faith, in accordance with the authority conferred by the health care directive; or

(b) for failing to make health care decisions on behalf of the maker.

Gift to witness, health care proxy, or person signing for maker.

13 Where a person or his or her then spouse is given or made a beneficial devise, bequest, or other disposition or appointment of or affecting real or personal property under the maker's will, or is named or whose then spouse is named as the beneficiary in the maker's life insurance policy, the devise, bequest, disposition or appointment and the receipt of proceeds of the insurance policy is not void by reason only that the person

(a) is a witness to the execution of the health care directive;

(b) is the health care proxy of the maker; or

(c) signs the health care directive on behalf of the maker.

Release of medical information.

14 Notwithstanding any restriction, whether statutory or otherwise, relating to the disclosure of confidential medical information, but subject to any express limitations in the health care directive, a health care proxy shall have the right to be provided with all information necessary to make informed health care decisions on behalf of the maker.

Existing rights.

15 Nothing in this Act abrogates or derogates from any rights or responsibilities now or hereafter conferred by statute or common law.

No presumption.

16 No inference or presumption shall arise by reason only that a person has not executed or has revoked a health care directive.

Offence and penalty.

17 Any person who, without the maker's consent, wilfully conceals, cancels, obliterates, damages, alters, falsifies or forges a health care directive or a revocation of a health care directive is guilty of an offence and liable on summary conviction to a fine of not more than $2,000.00 or to imprisonment for a term of not more than six months or to both.

Regulations.
18 The Lieutenant Governor in Council may make regulations prescribing a form for health care directives but the use of such form shall not be mandatory.

Reference in Continuing Consolidation.
19 This Act may be referred to as chapter H27 of the Continuing Consolidation of the Statutes of Manitoba.

Commencement of Act.
20 This Act comes into force on proclamation.

APPENDIX B

SAMPLE FORMS

HEALTH CARE DIRECTIVE [FORM B.1]

NOTICE: THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

This document allows you to do two things. In Part 1, you can give instructions about the health care to be given or not given to yourself in the future. In Part 2, you can appoint a person or persons (a health care proxy) to make health care decisions on your behalf (should your instructions in this document not be relevant to a decision which must be made or not be clearly communicated). If you wish, you may use this document for only one of these two things and leave the other part blank.

After you have completed Part 1 and/or Part 2, sign the document in Part 3. If you have appointed a proxy, he or she must also sign. If you are unable to sign, you may have someone else sign on your behalf but, if you do, you must also have a witness sign.

After you have signed this document, you continue to have the right to make health care decisions for yourself as long as you are mentally capable of doing so. **The instructions in this health care directive and the authority of your health care proxy become effective only when you become incapable of making or communicating your wishes for health care and they remain effective only for so long as you remain incapable of doing so.**

Your health care providers must, within the limits of reasonable medical practice and the law, act consistently with your instructions in this document and follow the directions of your health care proxy.

It is preferable that you appoint only one proxy to act at a time. **If you name more than one proxy, you must specify whether they are to act jointly or successively.** If you do not, they will be deemed to act successively. If you state that they are to act jointly, the decision of the majority will rule, unless you provide otherwise. If any of the named persons cannot act, those remaining will continue to have the authority to act on your behalf.

Your health care proxy will not have a duty to exercise the granted authority but, if your health care proxy does act, he or she must do so in good faith and consistently with your wishes. If your wishes are not known, your health care proxy must make health care decisions which he or she believes to be in your best interests. Unless you limit your proxy's power, your health care proxy will also have the authority to donate your organs after you die.

Review this document periodically to make sure it continues to reflect your wishes. This document will remain valid and in effect until and unless you revoke it. You can revoke it by making a new health care directive, by declaring in writing your intention to revoke it, or by destroying every original executed copy of this health care directive.

The instructions in this document will only be followed if its existence is known. **You should keep a copy of this document after you have signed it and may wish to keep a copy on you at all times. Give a copy to your health care proxy (if you appoint one) and to your doctor.** If you are a resident in a health care facility, a copy of this document should also be included in your medical record.

The use of health care directives is authorized by The Health Care Directives Act. That Act does not restrict the use of any other form of health care directive. **If there is anything in this document that you do not understand, you should obtain professional help to have it explained to you.**

HEALTH CARE DIRECTIVE

TO MY FAMILY, DOCTOR, AND ALL THOSE CONCERNED WITH MY CARE:

I,[print your name] _____,
being capable of giving instructions about my current medical treatment, make this health care directive to be followed if I lose the capacity to make or communicate decisions regarding my health care.

PART 1 - Health Care Wishes

[State your wishes as clearly as possible. Failure to do so may result in your wishes not being given effect.]
[You may attach additional pages if you wish.]

The following are my feelings and wishes regarding my health care:

_____

_____

_____

_____

_____

I particularly want to have the following health care:

_____

_____

_____

_____

I particularly do not want the following health care:

_____

_____

_____

_____

The following are thoughts that I feel are relevant to my instructions: [You may state your religious beliefs, philosophy, or other personal values that you feel are important.]

_____

_____

_____

_____

_____

PART 2 - Health Care Proxy

I appoint the following person(s) to be my health care proxy: [A proxy must be 18 years of age or older.]

Name: _____
Address: _____
Telephone Number: _____

Name: _____
Address: _____
Telephone Number: _____

If I have named more than one person, I want them to act: [Mark one with a check or x.]
successively_____ or jointly _____

Your proxy will have the same power and authority to make health care decisions for you as you would have if you were capable of making those decisions. If you wish to limit the scope of your health care proxy's powers, you may do so on the following lines.

_____
_____

PART 3 - Signatures

Signature of maker:_____ Date:_____

A substitute may sign on your behalf in your presence. In that case, a witness must also sign.

Signature of substitute signer: _____
Address: _____
Date:_____

Witness's declaration: I declare that the substitute signer signed this document at the request of and in the presence of the maker. Neither I nor the substitute signer are appointed as health care proxy by this document; neither I nor the substitute signer are the spouse of the health care proxy. I attest to and subscribe this health care directive in the presence of the maker.

Signature of witness: _____
Address: _____

Consent of health care proxy: [The appointment of your health care proxy is effective only if he or she consents by signing below.] I consent to my appointment as health care proxy.

Signature of proxy:_____ Date:_____

Signature of proxy:_____ Date:_____

HEALTH CARE DIRECTIVE [FORM B.2]

NOTICE: THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

This document allows you to do two things. In Part 1, you can give instructions about the health care to be given or not given to yourself in the future. In Part 2, you can appoint a person or persons (a health care proxy) to make health care decisions on your behalf (should your instructions in this document not be relevant to a decision which must be made or not be clearly communicated). If you wish, you may use this document for only one of these two things and leave the other part blank.

After you have completed Part 1 and/or Part 2, sign the document in Part 3. If you have appointed a proxy, he or she must also sign. If you are unable to sign, you may have someone else sign on your behalf but, if you do, you must also have a witness sign.

After you have signed this document, you continue to have the right to make health care decisions for yourself as long as you are mentally capable of doing so. **The instructions in this health care directive and the authority of your health care proxy become effective only when you become incapable of making or communicating your wishes for health care and they remain effective only for so long as you remain incapable of doing so.**

Your health care providers must, within the limits of reasonable medical practice and the law, act consistently with your instructions in this document and follow the directions of your health care proxy.

It is preferable that you appoint only one proxy to act at a time. **If you name more than one proxy, you must specify whether they are to act jointly or successively.** If you do not, they will be deemed to act successively. If you state that they are to act jointly, the decision of the majority will rule, unless you provide otherwise. If any of the named persons cannot act, those remaining will continue to have the authority to act on your behalf.

Your health care proxy will not have a duty to exercise the granted authority but, if your health care proxy does act, he or she must do so in good faith and consistently with your wishes. If your wishes are not known, your health care proxy must make health care decisions which he or she believes to be in your best interests. Unless you limit your proxy's power, your health care proxy will also have the authority to donate your organs after you die.

Review this document periodically to make sure it continues to reflect your wishes. This document will remain valid and in effect until and unless you revoke it. You can revoke it by making a new health care directive, by declaring in writing your intention to revoke it, or by destroying every original executed copy of this health care directive.

The instructions in this document will only be followed if its existence is known. **You should keep a copy of this document after you have signed it and may wish to keep a copy on you at all times. Give a copy to your health care proxy (if you appoint one) and to your doctor.** If you are a resident in a health care facility, a copy of this document should also be included in your medical record.

The use of health care directives is authorized by The Health Care Directives Act. That Act does not restrict the use of any other form of health care directive. **If there is anything in this document that you do not understand, you should obtain professional help to have it explained to you.**

HEALTH CARE DIRECTIVE

TO MY FAMILY, DOCTOR, AND ALL THOSE CONCERNED WITH MY CARE:

I,[print your name] _____,
being capable of giving instructions about my current medical treatment, make this health care directive to be followed if I lose the capacity to make or communicate decisions regarding my health care.

PART 1 - Health Care Wishes

[State your wishes as clearly as possible. Failure to do so may result in your wishes not being given effect.]
[You may attach additional pages if you wish.]

The following are my feelings and wishes regarding my health care:

_____

_____

_____

_____

_____

The following are thoughts that I feel are relevant to my instructions: [You may state your religious beliefs, philosophy, or other personal values that you feel are important.]

_____

_____

_____

_____

_____

The following are my feelings and wishes in these situations: [Place a check or an x in the appropriate boxes.][1]

	SITUATION (A) If I am in a coma or in a permanent vegetative state, and in the opinion of my physician and several consultants here no known hope of regaining awareness and higher mental functions no matter what is done, then my wishes regarding use of the following, if considered medically reasonable, would be				SITUATION (B) If I am in a coma, and I have a small likelihood of recovering fully, a slightly larger likelihood of surviving with permanent brain damage, and a much larger likelihood of dying, then my wishes regarding the use of the following, if considered medically reasonable, would be				SITUATION (C) If I have brain damage or some brain disease which cannot be reversed and which makes me unable to recognize people, or to speak understandably, *and I also have a terminal illness*, such as incurable cancer which will likely be the cause of my death, then my wishes regarding use of the following, if considered medically reasonable, would be				SITUATION (D) If I have brain damage or some brain disease which cannot be reversed and which makes me unable to recognize people, or to speak understandably, *but I have no terminal illness*, and I can live in this condition for a long time, then my wishes regarding use of the following, if considered medically reasonable, would be			
	I want	I do not want	I am undecided	I want a trial. If no clear improvement stop treatment	I want	I do not want	I am undecided	I want a trial. If no clear improvement stop treatment	I want	I do not want	I am undecided	I want a trial. If no clear improvement stop treatment	I want	I do not want	I am undecided	I want a trial. If no clear improvement stop treatment
1) CARDIOPULMONARY RESUSCITATION If on the point of dying the use of drugs and electric shock to start the heart beating and artificial breathing				■				■				■				■
2) MECHANICAL BREATHING - breathing by a machine																
3) ARTIFICIAL NUTRITION AND HYDRATION - nutrition and fluid given through a tube in the veins, nose, or stomach																
4) MAJOR SURGERY - such as removing the gall bladder or part of the intestines				■				■				■				■
5) KIDNEY DIALYSIS - cleaning the blood by machine or by fluid passed through the belly																
6) CHEMOTHERAPY - drugs to fight cancer																
7) MINOR SURGERY - such as removing some tissue from an infected toe				■				■				■				■
8) INVASIVE DIAGNOSTIC TESTS - such as using a flexible tube to look into the stomach				■				■				■				■
9) BLOOD OR BLOOD PRODUCTS -																
10) ANTIBIOTICS - drugs to fight infection																
11) SIMPLE DIAGNOSTIC TESTS - such as blood tests or x-rays				■				■				■				■
12) PAIN MEDICATIONS, EVEN IF THEY DULL CONSCIOUSNESS AND INDIRECTLY SHORTEN MY LIFE -				■				■				■				■

[1]This scenario-based table is taken from L.L. Emanuel and E.J. Emanuel, "The Medical Directive: A New Comprehensive Advance Care Document" (1989), 261 J.A.M.A. 3288 at 3290.

PART 2 - Health Care Proxy

I appoint the following person(s) to be my health care proxy: [A proxy must be 18 years of age or older.]

Name: _____
Address: _____
Telephone Number: _____

Name: _____
Address: _____
Telephone Number: _____

If I have named more than one person, I want them to act: [Mark one with a check or x.]
successively_____ or jointly _____

Your proxy will have the same power and authority to make health care decisions for you as you would have if you were capable of making those decisions. If you wish to limit the scope of your health care proxy's powers, you may do so on the following lines.

_____
_____

PART 3 - Signatures

Signature of maker:_____ Date:_____

A substitute may sign on your behalf in your presence. In that case, a witness must also sign.

Signature of substitute signer: _____
Address: _____
Date:_____

Witness's declaration: I declare that the substitute signer signed this document at the request of and in the presence of the maker. Neither I nor the substitute signer are appointed as health care proxy by this document; neither I nor the substitute signer are the spouse of the health care proxy. I attest to and subscribe this health care directive in the presence of the maker.

Signature of witness: _____
Address: _____

Consent of health care proxy: [The appointment of your health care proxy is effective only if he or she consents by signing below.] I consent to my appointment as health care proxy.

Signature of proxy:_____ Date:_____

Signature of proxy:_____ Date:_____

APPENDIX C

LIST OF PERSONS AND ORGANIZATIONS WHO RESPONDED TO THE DISCUSSION PAPER

Victoria General Hospital, Winnipeg
Manitoba Health Organizations Inc.
Christian Science Committee on Publication for Manitoba
Health Sciences Centre, Winnipeg
H.V. Rutherford, Winnipeg
Betty Kehler, Teulon
Donna Freeman, Winnipeg
A.L. Henderson, Brandon
Dying with Dignity (Canada)
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Manitoba Association of Community Health Centres
The Psychological Association of Manitoba
Manitoba Association for Rights and Liberties
Age & Opportunity, Issues Committee, Winnipeg
Alzheimer Society Manitoba Inc.
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Mr. and Mrs. J. Humeniuk, Winnipeg
The Lutheran Church - Canada, Winnipeg
Manitoba Association on Gerontology
Manitoba Association of Registered Nurses
Manitoba Council on Aging
Manitoba Medical Association
Manitoba Society of Seniors Inc.

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Dr. D.L. Kippen, Winnipeg
Women's Health Clinic, Winnipeg
Ted and Nadia Ewanchyshyn, Dauphin

LIST OF PERSONS AND ORGANIZATIONS TO WHOM COPIES OF THE DISCUSSION PAPER WERE SENT

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Graeme Garson, Deputy Minister of Justice and Attorney General, Province of Manitoba
Hon. Donald W. Orchard, Minister of Health, Province of Manitoba
Betty Havens, Provincial Gerontologist, Province of Manitoba
Agnes MacDonald, Chairperson, Manitoba Council on Aging
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Stuart Whitley, Director of Criminal Prosecutions, Department of Justice, Province of Manitoba
Sharon Carstairs, Leader of the Opposition, Province of Manitoba
Gary Doer, Leader of the New Democratic Party, Province of Manitoba
Anne Bolton, Acting Public Trustee, Province of Manitoba
Heidi Streu, Executive Director, Manitoba Association for Rights and Liberties
Carol J. Robertson, Executive Director, Manitoba Society of Seniors Inc.
William Martin, Executive Director, Canadian Mental Health Association, Manitoba Division
Jane Stewart, Manitoba Medical Association-Manitoba Bar Association Liaison Committee Manitoba Medical Association
Todd Campbell, Manitoba Medico-Legal Society
Sherri Wiebe, Chairperson, Health Law Subsection, Manitoba Bar Association
Martin Glazer, Chairperson, Civil Liberties Subsection, Manitoba Bar Association
Prof. Barney Sneiderman, Faculty of Law, University of Manitoba
Dean Roland Penner, Faculty of Law, University of Manitoba
Marshall Braunstein, lawyer, Winnipeg
Michael Werier, lawyer, Winnipeg
William J. Burnett, lawyer, Winnipeg
Gwen Fletcher, Interim Executive Director, Victoria General Hospital, Winnipeg

Dr. Ferdinand Pauls, Medical Director, Seven Oaks General Hospital, Winnipeg
T. Bartman, Executive Director, Misericordia General Hospital, Winnipeg
Dr. H. Dirks, Medical Director, Concordia General Hospital, Winnipeg
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Dr. Ross Brown, Vice President Medical, St. Boniface General Hospital, Winnipeg
R. Brown, Executive Director, Deer Lodge Centre, Winnipeg
N.R. Kasian, Executive Director, Winnipeg Municipal Hospitals
Dr. A. Aizenman, Medical Director, Brandon General Hospital
G. Mattin, Executive Director, Portage District General Hospital, Portage la Prairie
W.H. Harris, Executive Director, Dauphin General Hospital
E. Avison, Executive Director, Flin Flon General Hospital
Robert Lee, Executive Director, Thompson General Hospital
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Dr. Paul Henteleff, Palliative Care Unit, St. Boniface General Hospital, Winnipeg
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Dr. D. Rodgers, Provincial Director of Psychiatric Services, Province of Manitoba
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Barbara Wiktorowicz, Executive Director, Alzheimer Society of Manitoba
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St. Demetrios Greek Orthodox Church, Winnipeg
Salvation Army, Winnipeg
Baptist Union of Western Canada, Winnipeg
Anglican Church of Canada, Winnipeg
Mennonite Central Committee, Winnipeg
United Church of Canada, Winnipeg
Church of Jesus Christ of Latter-Day Saints, Winnipeg
Jehovah's Witnesses Assembly Hall, Winnipeg
Consistory of Ukrainian Orthodox Church, Winnipeg
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Archdiocese of Winnipeg
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Ted and Nadia Ewanshyshyn, Dauphin

Dorothy Hardy, Age and Opportunity, Winnipeg

Peggy Lidstone, Beausejour

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Executive Staff, Health Sciences Centre, Winnipeg
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Vi McLean, Winnipeg
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James Wyllie, lawyer, Ottawa, Ontario
Diane Cullen, Manitoba Association of Social Workers
Herb Liffman, lawyer, Winnipeg
Lou-Anne Buhr, Assistant Deputy Minister, Department of Culture, Heritage and Recreation, Province of Manitoba

APPENDIX D

DISCUSSION PAPER ON ADVANCE DIRECTIVES AND DURABLE POWERS OF ATTORNEY FOR HEALTH CARE

July, 1990

Manitoba

Law Reform Commission

Commission de réforme du droit

12th Floor
Woodsworth Building
405 Broadway
Winnipeg, Manitoba, CANADA
R3C 3L6

(204) 945-2896

DISCUSSION PAPER ON ADVANCE DIRECTIVES AND DURABLE POWERS OF ATTORNEY FOR HEALTH CARE

July, 1990

The Manitoba Law Reform Commission was established by *The Law Reform Commission Act* in 1970 and began functioning in 1971.

Commissioners:

Clifford H.C. Edwards, Q.C., *President*
John C. Irvine
Gerald O. Jewers, J.
Eleanor R. Dawson, Q.C.
Pearl K. McGonigal

Executive Director:

Jeffrey A. Schnoor

Legal Counsel:

Iris C. Allen (part-time)
Barbara Hendrickson
Jayne Kapac
Marilyn Pilon

Administrator:

Suzanne Pelletier

The Commission offices are located on the 12th floor of the Woodsworth Building, 405 Broadway, Winnipeg, Manitoba R3C 3L6. Tel. (204) 945-2896, Fax (204) 945-8981.

Persons wishing to respond to the issues raised in this Discussion Paper are invited to write to the Commission at the following address:

Manitoba Law Reform Commission
12th floor
405 Broadway
Winnipeg, Manitoba
R3C 3L6

Unless clearly marked to the contrary, the Commission will assume that comments received are not confidential and that commentators agree to the Commission quoting from or referring to their comments, in whole or in part, and to the comments being attributed to them. However, requests for confidentiality or anonymity will be respected to the extent permitted by *The Freedom of Information Act*.

We request that comments be submitted to the Commission not later than October 31, 1990.

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CHAPTER 1

INTRODUCTION

The nightmare began . . . [more than] seven years ago. In the early-morning hours of Jan. 11, 1983, Nancy Cruzan's car swerved on an icy and deserted Missouri country road. The car flipped and crashed. The 25-year-old woman tumbled out and landed facedown in a ditch. Medical help arrived promptly enough to save her life but not fast enough to save her oxygen-deprived brain.

Nancy Cruzan never regained consciousness after that accident, and doctors say she never will. Now 32, she lies in a condition known as a persistent vegetative state, awake but totally unaware, at the Missouri Rehabilitation Center at Mount Vernon. Her body is stiff and severely contracted, her knees and arms drawn into a fetal position, her fingers dug into her wrists. Some nurses report that Cruzan can turn toward persons who speak to her and that she has cried on several occasions, once when a valentine card was read to her. But doctors say she is oblivious to the environment except for reflective responses to sound and painful stimuli. "We have literally cried over Nancy's body, and we've never seen anything," says her anguished father Joe Cruzan. "Sometimes you swear she is looking right at you, but then you move three or four steps. She has no awareness of herself."

A tube to Cruzan's stomach provides all the food and water that keep her on this side of existence. The cost of her care, $130,000 annually, is borne by the state . . . . Doctors say her heart could beat and her lungs could breathe for 30 more years, but her parents want the feeding stopped so that she can die in peace now.[1]

* * *

. . . [Earle N. Spring suffered] from "end-stage kidney disease," which required him to undergo hemodialysis treatment (filtering of the blood) three days a week, five hours a day. He also suffered from "chronic organic brain syndrome," or senility, and was completely confused and disoriented. Both the kidney disease and the senility were permanent and irreversible; there was no prospect of a medical breakthrough that would provide a cure for either disease. Apart from the kidney disease and senility . . . [Mr. Spring's] health was good.

Without the dialysis treatment . . . [he] would die; with it he might survive for months. Survival for five years would be not probable, but conceivable. The treatment did not cause a remission of the disease or restore him even temporarily to a normal, cognitive, integrated, functioning existence, but simply kept him alive. He experienced unpleasant side effects such as dizziness, leg cramps, and headaches; on occasion he kicked nurses, resisted transportation for dialysis, and pulled the dialysis needles out of his arm. His disruptive behaviour was controlled through heavy sedation. He would not have suffered any discomfort if the dialysis had been terminated. There was no evidence that while competent he had expressed any wish or desire as to the continuation or withdrawal of treatment in such circumstances, but his wife and son were of the opinion that if competent he would request withdrawal of treatment.[2]

Rapid advances in medical technology have proven a boon to humanity, saving lives where death was once a certainty. At the same time, these advances have spawned new and difficult

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[1] "Whose Right to Die?", *Time* (Can. ed.), December 11, 1989, 65. On June 25, 1990, the United States Supreme Court ruled in a 5-4 vote that Nancy Cruzan's parents could not order her doctors to remove tubes which provide her with food and water. "Chief Justice William Rehnquist, writing for the court, said, 'We assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.' But in Ms Cruzan's case, such 'clear and convincing' proof that she would want to die is lacking, and it is too risky to leave the decision to anyone else, even loving parents": "Comatose protected", *The Globe and Mail* (Nat. ed.), June 26, 1990, A6.

[2] *In the Matter of Earle N. Spring*, 405 N.E. 2d 115 at 118 (Mass. 1980).

problems with which the law has often had difficulty keeping up.

This Discussion Paper considers one such problem: the situation of the individual who, through age, illness or accident, loses the ability to communicate his or her wishes respecting medical treatment.[3] Although it is popularly assumed that that wish will be to terminate medical treatment (to "pull the plug" or to "die in dignity"), that will often not be the case. The wish may instead be that heroic measures be taken to ensure the continuation of life. It may simply be that one course of treatment be chosen over another. Should there be a mechanism which ensures that the wishes of the individual are respected? Does it make a difference if those wishes would result in the death of the individual? If there is to be legal recognition of the wishes of the individual, how does the law ensure that the wishes are made known and that they are not thwarted by others?

As is so often the case with problems in the law, a balancing of competing principles is at the core. Should the law favour the principle of personal autonomy and control over one's body or does society place such a high value on human life that it cannot contemplate individuals authorizing the termination of medical treatment in extreme cases? In an age of scarce financial resources, would society actually prefer such authorizations in order to avoid a drain on health care budgets, or is such a thought the slippery slope to euthanasia of those who are troublesome to society, financially or otherwise?

We make no attempt to answer these questions in this Discussion Paper. However, we recognize that we must be conscious of these philosophical dilemmas as we search for methods of making the law responsive to the changes in society which medical science has wrought. In this Discussion Paper, we propose to provide the factual information needed to begin the debate on certain specific questions. In Chapter 2, we set out the current state of the law respecting consent to medical treatment and explain why it is generally not possible to bind others to your wishes respecting medical treatment once you are incompetent, even if they have been clearly expressed prior to that incompetence. We then ask whether the present state of the law is satisfactory and conclude the Chapter by setting out two mechanisms by which the law might be changed (assuming reform is called for) in order to give some binding effect to clear expressions of will respecting medical treatment: the advance directive (popularly known as the "living will") and the durable power of attorney for health care. For readers who are interested in more than an overview of these two mechanisms, we discuss in Chapter 3 issues which concern the implementation of advance directives and durable powers of attorney for health care. Finally, in Chapter 4, we pose a series of questions for discussion, beginning with whether the law should be reformed and what mechanisms are appropriate and ending with how those mechanisms might be implemented; reference is made to the areas in the Paper where each question is discussed.

This Discussion Paper is distributed by the Manitoba Law Reform Commission in order to elicit comments from interested individuals and organizations about the issues raised in it. Once these comments have been received, the Commission will consider them and then prepare its Report on advance directives respecting medical treatment. In accordance with *The Law Reform Commission Act*, that Report will in turn be submitted to the Minister of Justice and Attorney General of Manitoba for his consideration.

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[3]Our discussion is restricted to individuals who were competent to express their wishes respecting medical treatment and subsequently lose that competence or capacity. It does not relate to individuals who never had that capacity. An aspect of this latter issue will be considered in the Manitoba Law Reform Commission's forthcoming Discussion Paper on sterilization, minors, the mentally incompetent, and the Supreme Court of Canada's decision in *Re Eve* (1986), 31 D.L.R. (4th) 1 (S.C.C.).

Persons wishing to respond to the issues raised in this Discussion Paper are invited to write to the Commission at the following address:

Manitoba Law Reform Commission
12th Floor
405 Broadway
Winnipeg, Manitoba
R3C 3L6

Unless clearly marked to the contrary, the Commission will assume that comments received are not confidential and that commentators agree to the Commission quoting from or referring to their comments, in whole or in part, and to the comments being attributed to them. However, requests for confidentiality or anonymity will be respected to the extent permitted by *The Freedom of Information Act*.

We request that comments be submitted to the Commission not later than October 31, 1990.

CHAPTER 2

THE PRESENT LAW: PROBLEMS AND SOLUTIONS

In this Chapter, we summarize the present state of the law as it relates to consent to medical treatment and, in particular, we examine the reasons why a direction relating to that treatment made while an individual is competent will not necessarily be honoured during a subsequent period of incompetence. We also set out the reasons which have been put forward for reforming this area of the law and ask whether reform is indeed warranted. We conclude by discussing two reform options which have been proposed: the advance directive (popularly known as the living will) and the durable power of attorney for health care.

A. SELF-DETERMINATION

Every person who understands the nature and consequences of proposed medical treatment has a right to consent to or refuse that treatment.[1] The right is based on the principle of self-determination: a person has the right to decide what, if anything, is to be done to his or her body.[2] The principle of self-determination has been explained this way:

> . . . [O]ur law is clear that the consent of a patient must be obtained before any surgical procedure can be conducted. Without a consent, either written or oral, no surgery may be performed. This is not a mere formality; it is an important individual right to have control over one's own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed, where it will be done, when it will be done and by whom it will be done.[3]

The right of self-determination goes so far as to entitle a competent individual to refuse treatment which is beneficial or necessary, even if death may result.[4] For example, in the recent case of *Malette* v. *Shulman*, the Ontario Court of Appeal upheld the refusal of life-saving blood transfusions by a Jehovah's Witness. As Robins J.A. stated for the Court:

> The right of self-determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment. The patient is free to decide, for instance, not to be operated on or not to undergo therapy or, by the same token, not to have a blood transfusion. If a doctor were to proceed in the face of a decision to reject the treatment, he would be civilly liable for his unauthorized conduct notwithstanding his justifiable belief that what he did was necessary to preserve the patient's life or health. The doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care. For this freedom to be meaningful, people must have the right to make choices that accord with their own values regardless of how unwise or foolish those choices may appear to others. . . .[5]

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[1] *Mulloy* v. *Hop Sang*, [1935] 1 W.W.R. 714 (S.C. App. Div.); *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.).

[2] *Hopp* v. *Lepp*, [1980] 2 S.C.R. 192.

[3] *Allan* v. *New Mount Sinai Hospital* (1980), 109 D.L.R. (3d) 634 at 642 (Ont. H.C.), rev'd on pleading issue (1981), 125 D.L.R. (3d) 276 (C.A.).

[4] *Manny* v. *Carter-Halls-Aldinger Company Limited*, [1929] 3 W.W.R. 741 (Sask. K.B.).

[5] *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 at 328 (Ont. C.A.).

The principle of self-determination is not absolute. For example, it may be impractical in an emergency situation to obtain the consent of a patient; he or she may be unconscious. In this circumstance, a physician may treat a patient without the patient's consent. Medical services are provided either on the rationale of implied consent[6] (that is, the law assumes, in the absence of evidence to the contrary, that the patient would wish appropriate life-saving steps to be taken in an emergency) or on the basis that the physician is privileged by reason of necessity.[7] In addition, an individual's right to self-determination may be overridden by the state's interest in preserving life, protecting innocent third parties, preventing suicide and maintaining the ethical integrity of the medical profession. For example, an individual may be required to "submit to medical procedures in order to eliminate a health threat to the community or . . . [he or she may be prohibited] from engaging in activities which are inherently dangerous to . . . [his or her life]"[8] such as committing suicide or senselessly maiming or disfiguring himself or herself. At the opposite extreme of limitation on self-determination, a person cannot insist upon receiving extraordinary treatment that is scarce or expensive; its allotment is governed not only by the needs of the individual, but by those of others in the facility and the community.[9] Finally, a person who refuses to receive ordinary treatment may be required to leave a health care facility or may forfeit any right to sue for the consequences of incomplete care.

Persons who do not understand the nature and consequences of proposed treatment (generally minors and mentally incompetent adults) must rely on the decisions of a substitute decision maker.[10] A parent or guardian with legal custody can provide consent or refusal for a minor. A court-appointed committee[11] with custody of the person (as opposed to the person's estate) and authority to consent to medical treatment, or the Public Trustee, can consent to or refuse treatment for a mentally incompetent adult.[12] In practice, however, where the family is in agreement and the proposed care is clearly beneficial to the incompetent adult,[13] the family and the patient's physician make treatment decisions on their own instead of instituting court proceedings for the appointment of a committee. A substitute decision maker may consent only to therapeutic treatment which is in the best interests of the patient. Where the decision is not in his or her best interests and is clearly wrong, a court may intervene.[14]

In most cases, a person who was once competent but who subsequently has become incompetent to accept or refuse medical treatment is treated in the same manner as a minor or an adult who always lacked competence. He or she must rely on a substitute decision maker. Even where the previously expressed wishes of the person are known, there is no assurance that effect will be given to them. However, the law seems to be changing in this area. It has recently been decided by the Ontario Court of Appeal that, in certain cases, a patient's prior instructions

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[6]*Marshall* v. *Curry*, [1933] 3 D.L.R. 260 at 268 (N.S.S.C.); *Parmley* v. *Parmley*, [1945] S.C.R. 635 at 646.

[7]*Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.).

[8]*Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 at 333 (Ont. C.A.).

[9]B.M. Dickens, "The Right to Natural Death" (1981), 26 McGill L.J. 847.

[10]*Institut Philippe Pinel de Montréal* v. *Dion* (1983), 2 D.L.R. (4th) 234 (Que. Sup. Ct.); G.B. Robertson, *Mental Disability and the Law in Canada* (1987) 3.

[11]This is a legal term referring to the person to whom the care of another has been *committed*. It is pronounced with the accent on the final syllable.

[12]*The Mental Health Act*, C.C.S.M. c. M110, ss. 80(1), (1.1)(c).

[13]K. Evans, "Mental Competence, Treatment and Substitute Consent: A Lawyer's Perspective" (1988), 8 Health L. Can. 96.

[14]The court's authority is based on provincial legislation, see *The Child and Family Services Act*, C.C.S.M. c. C80, ss. 17(2)(b)(iii) and 38 and *The Mental Health Act*, C.C.S.M. c. M110, s. 60 or its *parens patriae* jurisdiction: *Re Eve* (1986), 31 D.L.R. (4th) 1 (S.C.C.).

concerning medical treatment given when the patient was competent must be recognized by physicians. The Court ruled that a written objection to the administration of blood or blood products by a Jehovah's Witness constituted a valid restriction on a physician's right to treat the patient which must be honoured after the patient becomes incompetent. Robins J.A. stated:

> A doctor is not free to disregard a patient's advance instructions any more than he would be free to disregard instructions given at the time of the emergency . . . . While the law may disregard the absence of consent in limited emergency circumstances, it otherwise supports the right of competent adults to make decisions concerning their own health care by imposing civil liability on those who perform medical treatment without consent.[15]

However, Robins J.A. made it clear that he had considered the law only as it pertained to the case before him and not "the law that may be applicable to the many situations in which objection may be taken to the use or continued use of medical treatment to save or prolong a patient's life." In particular, he said:

> . . . [W]e are not concerned with a patient who has been diagnosed as terminally or incurably ill who seeks by way of advance directive or "living will" to reject medical treatment so that she may die with dignity; neither are we concerned with a patient in an irreversible vegetative state whose family seeks to withdraw medical treatment in order to end her life; nor is this a case in which an otherwise healthy patient wishes for some reason or other to terminate her life.[16]

Time will tell whether prior refusals of treatment or consents to treatment in other circumstances will be honoured. Until then, a patient's previously expressed wishes may have no binding effect and may serve only as guidelines to physicians, the weight given to them being dependent on their formality, similarity to conventional medical practice, timing with respect to the onset of the patient's illness and whether the patient's family concurs with his or her wishes. In part, previously expressed wishes may be afforded this treatment because it is assumed that instructions given before the onset of the actual event or illness cannot truly be informed. This is also because of the law surrounding the civil and criminal liability of care givers; we explore this issue in the next section of this Chapter.

B. LIABILITY OF CARE GIVERS

Physicians and other health care givers are subject to a variety of provisions of civil and criminal law which, in addition to governing their conduct, affect the ability of the patient to control his or her own health care.

As we have seen, treatment may proceed only where informed consent has been given by the patient or his or her substitute decision maker. Where a patient receives treatment for which informed consent was not given, or where the consent was obtained by fraud or misrepresentation, the physician may be liable for the tort of battery.[17] In the *Malette* case, Robins J.A. said this about informed consent:

> The doctrine of informed consent has developed in the law as the primary means of protecting a patient's right to control his or her medical treatment. Under the doctrine, no medical procedure may be undertaken without the patient's consent obtained after the patient has been provided with sufficient information to evaluate the risks and benefits of the proposed treatment and other available options. The doctrine presupposes the patient's capacity to make a subjective

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[15] *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 at 330 (Ont. C.A.).

[16] *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 at 332 (Ont. C.A.).

[17] *Allan* v. *New Mount Sinai Hospital* (1980), 109 D.L.R. (3d) 634 (Ont. H.C.); *Reibl* v. *Hughes*, [1980] 2 S.C.R. 880; *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.). For an application to minors, see *Re "D" and Council of the College of Physicians and Surgeons of British Columbia* (1970), 11 D.L.R. (3d) 570 (B.C.S.C.). In law, the tort of battery refers to an unauthorized or unconsented-to touching or physical contact.

> treatment decision based on her understanding of the necessary medical facts provided by the doctor and on her assessment of her own personal circumstances. A doctor who performs a medical procedure without having first furnished the patient with the information needed to obtain an informed consent will have infringed the patient's right to control the course of her medical care, and will be liable in battery even though the procedure was performed with a high degree of skill and actually benefitted the patient.
>
> . . .
>
> By imposing civil liability on those who perform medical treatment without consent even though the treatment may be beneficial, the law serves to maximize individual freedom of choice.[18]

It is untested in Canada whether an advance directive given by an individual in anticipation of subsequently becoming incompetent is to be regarded as an informed consent even though an individual could not possibly be informed of all the possible treatments and risks relating to a future hypothetical event. Liability for battery does not depend on actual harm or on an immediate awareness by the patient of the interference. The act itself, if unaccompanied by valid informed consent, is sufficient to found liability; as we have seen, this is so even if the treatment was medically helpful. Generally, compensation may be awarded for all consequences of the wrongful conduct, whether unintentional or unforeseeable.[19] In addition to civil liability for battery, treatment without consent may give rise to criminal liability for assault (defined in section 265) pursuant to section 266 of the *Criminal Code*.

Liability in negligence for malpractice may result where a physician does not act in a reasonable and prudent manner. The physician's conduct is measured against an objective standard which accounts for any extra or specialized knowledge possessed by the physician. The onus is on the patient to establish substandard, negligent conduct.[20] A physician may also be liable in negligence where he or she fails to make appropriate disclosure to the patient of all of the risks attendant to a proposed medical procedure. He or she must disclose the nature of a proposed operation, its gravity, material risks, associated special or unusual risks as well as any other information that a reasonable person in the patient's position would require.[21]

Once treatment is commenced, necessary treatment must be continued in accordance with the consent. Failure to do so may give rise to damages. Criminal liability may also arise. Section 217 of the *Criminal Code* imposes a duty on a person who undertakes an act to continue it, if an omission to do so may be dangerous to life. A person is criminally negligent if he or she omits to do anything that it is his or her duty to do, showing "wanton or reckless disregard for the lives or safety of other persons".[22] Theoretically, a physician who discontinues a patient's treatment (for example, by turning off a respirator) could come within the scope of these

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[18] *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 at 327-328 and 334 (Ont. C.A.).

[19] *Allan* v. *New Mount Sinai Hospital* (1980), 109 D.L.R. (3d) 634 (Ont. H.C.); A.M. Linden, *Canadian Tort Law* (4th ed., 1988) 40-43 and 64-65. Some American cases have suggested that damages may be available for pain, suffering and expenses incurred because life is prolonged by unwanted treatment: *In re Bayer*, No. 4131, N.D. Burleigh County Ct., Feb. 5 and Dec. 11, 1987, Riskedahl J. (damages were not awarded in the case because of a lack of evidence.); *Leach* v. *Shapiro*, 13 Ohio App. 3d 393, 469 N.E. 2d 1047 (1984). However, B.M. Dickens speculates that such a claim would face several difficult obstacles in Canada. Courts would have to recognize that death is preferable to life in certain circumstances. (Canadian courts seem to have accepted this. See, for example, *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.).) Damages for unwanted life would be difficult to quantify and may be insubstantial in many cases, such as where the patient survives in an unconscious or vegetative state. In addition, proving the unlawfulness of life-preserving treatment would be difficult if necessity is an available defence: B.M. Dickens, "The Right to Natural Death" (1981), 26 McGill L.J. 847 at 853-856.

[20] A.M. Linden, *Canadian Tort Law* (4th ed., 1988) 142-143 and 148-149.

[21] *Hopp* v. *Lepp*, [1980] 2 S.C.R. 192 at 210.

[22] *Criminal Code*, R.S.C. 1985, c. C-46, s. 219(1)(b).

sections.[23] If death ensues, the physician may be liable for causing death by criminal negligence (pursuant to section 220 of the *Criminal Code*). This might occur even if the patient had consented to the termination of treatment, since the *Criminal Code* provides that the criminal liability of a person who inflicts death upon another person is unaffected by that person's consent.[24]

Even worse, the physician may be charged with murder. Paragraph 229(a)(ii) of the *Criminal Code* provides that a person commits murder when he or she causes death by intentional bodily harm that he or she knows will likely cause death, being reckless as to whether death occurs. A strict interpretation of this paragraph may mean that a physician who administers pain-relieving drugs to a terminally-ill patient, which has the side-effect of shortening the life of that patient, may incur criminal liability. Again, liability might occur notwithstanding the patient's consent to treatment.[25] However, as the Law Reform Commission of Canada points out:

> In practice, Canadian case-law has no record of conviction of a doctor for shortening a terminal patient's life by administering pain-relieving drugs. Moreover, most people, including religious leaders, see nothing wrong in giving treatment for the purpose of relieving pain in certain circumstances even though one result of such relief may be to shorten life.[26]

Where treatment does not conform with the patient's consent or with standards of competence, the physician may, in addition to civil and criminal liability, face charges of misconduct from the body governing the medical profession.

The result of these potential sources of civil and criminal liability, in combination with the requirement for informed consent to all medical procedures, is a powerful incentive for physicians to disregard directions given by incompetent patients at an earlier time when they were competent. Whether these directions are to terminate treatment, take heroic measures, or administer certain procedures, with the exception of the judicial acceptance in one case of the refusal of treatment by a Jehovah's Witness, they have no binding legal force and may, in certain circumstances, expose the physician to serious jeopardy if followed.

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[23]However, commentators consider criminal liability based on section 217 to be unlikely for several reasons. First, criminal sanctions are limited by section 45. It provides that anyone who surgically operates upon a person for that person's benefit, using reasonable skill and care when it is reasonable to do so, is not subject to criminal liability. Secondly, continuation of treatment may not be reasonable (and therefore discontinuance of treatment not culpable) in every circumstance; this may be so, for example, for patients in irreversible comas: Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Working Paper #28, 1982) 17-18. As one set of authors stated: "We can confidently assert that the judiciary would reject the absurd proposition that when treatment becomes therapeutically useless, the physician is nonetheless locked into a duty to provide aggressive medical management until such time as the patient is pronounced brain-dead.": B. Sneiderman, J.C. Irvine and P.H. Osborne, *Canadian Medical Law* (1989) 324. Thirdly, prosecutors may be reluctant to institute criminal proceedings against physicians of good reputation who must act in difficult circumstances: E.J. Gurney, "Is there a Right to Die? - A Study of the Law of Euthanasia" (1972), 3 Cumberland-Samford L. Rev. 235 at 249. Although these limitations on liability are somewhat speculative, the unlikelihood of criminal sanctions is demonstrated by the absence of prosecutions and convictions against physicians for deaths which follow the discontinuance of treatment, a practice which is prevalent throughout Canada: Law Reform Commission of Canada, *Recodifying Criminal Law* (Report #31, 1987) 60; G. Ferguson, "The Canadian Charter of Rights and Individual Choice in Treatment" (1988), 8 Health L. Can. 63 at 67. Similarly, in the U.S. there are no reported cases of prosecutions against physicians who discontinue or do not administer extraordinary medical treatment.: E.J. Gurney, "Is there a Right to Die? - A Study of the Law of Euthanasia" (1972), 3 Cumberland-Samford L. Rev. 235.

[24]*Criminal Code*, R.S.C. 1985, c. C-46, s. 14.

[25]*Criminal Code*, R.S.C. 1985, c. C-46, s. 14.

[26]Law Reform Commission of Canada, *Recodifying Criminal Law* (Report #31, 1987) 60-61, referring to Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Working Paper #28, 1982) 8.

C. THE IMPACT OF THE *CHARTER*

As we have seen, the *Criminal Code* provides powerful reasons why physicians should disregard advance directions from patients, particularly when the instructions are to terminate or withhold treatment. However, it may be argued that the *Canadian Charter of Rights and Freedoms* will have the effect of giving the right to control one's own health care primacy over these provisions of the *Criminal Code*.[27] In this section, we examine those provisions of the *Charter* which may found such arguments. It must, however, be recognized that, at this early stage of the *Charter*'s existence, our discussion is essentially speculative.

Section 7 of the *Charter* may provide the broadest protection of the right to consent to or refuse medical treatment. It provides that everyone has the right to life, liberty and security of the person and the right not to be deprived of these rights except in accordance with principles of fundamental justice. The Ontario Court of Appeal said this about the protection afforded by section 7:

> Some rights have their basis in common law or statute law. Some are so deeply rooted in our traditions and way of life as to be fundamental and could be classified as part of life, liberty and security of the person. The right to choose one's partner in marriage, and the decision whether or not to have children, would fall in this category, as would the right to physical control of one's person, such as the right to clothe oneself, *take medical advice and decide whether or not to act on this advice*.[28] [emphasis added]

The elements of section 7 have also been independently analyzed. The first element, 'right to liberty', "guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives"[29] without state interference. A decision of this type is whether or not to have children. Wilson J. described it as a decision which has "profound psychological, economic and social consequences for the pregnant woman" in "complex and varied" circumstances fraught with "powerful considerations militating in opposite directions" and which "deeply reflects the way the woman thinks about herself and her relationship to others and to society at large."[30] These comments could also describe the decision to consent to or refuse medical treatment.

The second element, the 'right to security of the person', protects physical and psychological integrity. In the words of Dickson C.J.C.: ". . . [S]tate interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitute a breach of security of the person."[31] In Wilson J.'s opinion, "[s]tate enforced medical or surgical treatment . . . [is] an obvious invasion of physical integrity", and state interference in a woman's decision to have or not to have children infringes her right to personal autonomy in decision-making, directly interferes with her physical person and is contrary to human dignity and self-respect.[32] While this might seem to suggest by analogy that the criminal law cannot stand in the way of an individual's decision concerning medical treatment, the 'right to security of the person' may also be interpreted very differently. One commentator suggests

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[27]This assumes, of course, that the *Charter* has application to the situation under consideration. The *Charter* applies only where a governmental nexus exists: *Retail, Wholesale & Department Store Union, Local 580* v. *Dolphin Delivery Ltd.* (1986), 33 D.L.R. (4th) 174 (S.C.C.). Arguably, this may be found in the enabling legislation which establishes hospitals, nursing homes and special care homes as quasi-governmental bodies and in our government-funded health care system: F. Camerie, "Euthanasia and Self-Determinism: Is There a *Charter* Right to Die in Canada?" (1987), 32 McGill L.J. 299 at 303-305.

[28]*R.* v. *Morgentaler* (1985), 22 D.L.R. (4th) 641 at 665 (Ont.C.A.).

[29]*Morgentaler* v. *The Queen* (1988), 44 D.L.R. (4th) 385 at 490 (S.C.C.).

[30]*Morgentaler* v. *The Queen* (1988), 44 D.L.R. (4th) 385 at 490 (S.C.C.).

[31]*Morgentaler* v. *The Queen* (1988), 44 D.L.R. (4th) 385 at 401 (S.C.C.).

[32]*Morgentaler* v. *The Queen* (1988), 44 D.L.R. (4th) 385 at 492 (S.C.C.).

that it protects individuals by allowing government to prevent the terminally ill from refusing medical treatment.[33]

The third element of section 7, the 'right to life' may also protect the right to consent to or refuse medical treatment since it may allow a properly informed competent adult to determine his or her personal limits of an unbearable quality of life.[34]

The right to consent to or refuse medical treatment may also be protected by subsection 2(a) of the *Charter*. It provides that everyone has the freedom to follow their conscience and religion. Conscience and religion are separate entities. 'Freedom of religion' has been interpreted by the courts to allow an individual to hold and profess beliefs openly and observe the essential practices demanded by the tenets of his or her religion.[35] Accordingly, a person may refuse medical treatment in accordance with his or her religion even where death might result; as we have seen, the refusal of life-saving blood transfusions by a Jehovah's Witness has been upheld.[36] However, freedom of religion does not provide absolute protection. Courts have ruled that a child's health takes precedence over the parents' right to provide medical treatment in accordance with their religious beliefs and have intervened where parents have refused necessary medical treatment for their children.[37] 'Freedom of conscience' protects conscientious beliefs which are not religiously motivated.[38] Its protection may be more limited than that provided by 'freedom of religion' and might not allow an individual to adhere to a conscientious belief which may result in death.[39]

It is less clear whether section 12 of the *Charter* might protect the right to consent to or refuse medical treatment. This section provides that everyone has the right not to be subjected to cruel and unusual treatment or punishment. One case and several commentators suggest that the section may protect individuals from unusual or experimental therapy which exceeds necessary medical attention and which is cruel and unusual,[40] while another case suggests that the provision does not apply to medical treatment.[41]

Although it would seem that sections 2(a), 7 and 12 of the *Charter* might protect an individual's right to consent to or refuse medical treatment, this is not necessarily so. Section 1 permits the limitation of *Charter* rights when the limits are prescribed by law and where two criteria are met. The objective of the limitation must be of "sufficient importance to warrant overriding a constitutionally protected right or freedom"; that is, it must concern a matter which is pressing and substantial.[42] In addition, the method of overriding the right or freedom must be reasonable and demonstrably justified in a free and democratic society or proportional to the

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[33]F. Carnerie, "Euthanasia and Self-Determinism: Is there a *Charter* Right to Die in Canada?" (1987), 32 McGill L.J. 299 at 323.

[34]F. Carnerie, "Euthanasia and Self-Determinism: Is there a *Charter* Right to Die in Canada?" (1987), 32 McGill L.J. 299 at 322.

[35]*R.* v. *Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295.

[36]See, *Malette* v. *Shulman* (1987), 47 D.L.R. (4th) 18 at 47-48 (Ont. H.C.), where the *Charter* argument was not raised but the judge intimated that a refusal of medical treatment on religious grounds would be an appropriate *Charter* argument.

[37]See, *Re D.* (1982), 30 R.F.L. (2d) 277 (Alta. Prov. Ct.) and *Re McTavish and Director, Child Welfare Act* (1986), 32 D.L.R. (4th) 394 (Alta. Q.B.).

[38]*Morgentaler* v. *The Queen* (1988), 44 D.L.R. (4th) 385 at 495 (S.C.C.).

[39]F. Carnerie, "Euthanasia and Self-Determinism: Is there a *Charter* Right to Die in Canada?" (1987), 32 McGill L.J. 299 at 326.

[40]*Re S.D.* (1983), 42 B.C.L.R. 153 at 172 (Prov. Ct.); F. Carnerie, "Euthanasia and Self-Determinism: Is there a *Charter* Right to Die in Canada?" (1987), 32 McGill L.J. 299 at 327-330; R. Samek, "Euthanasia and Law Reform" (1984), 17 Ottawa L. Rev. 86 at 102.

[41]*Re McTavish and Director, Child Welfare Act* (1986), 32 D.L.R. (4th) 394 at 409 (Alta. Q.B.).

[42]*R.* v. *Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 at 352.

ends. Proportionality is achieved when the method is rational, fair and not arbitrary, the freedom or right under consideration is minimally impaired and its limitation is appropriate to the sought-after objective.[43]

The *Criminal Code* provisions discussed in the preceding section theoretically limit an individual's right to consent to or refuse medical treatment. However, whether the *Charter* applies to the right of individuals to make personal medical treatment decisions, whether the *Criminal Code* provisions violate the rights and freedoms guaranteed by the *Charter* and whether any such violation is reasonable and justified according to section 1 of the *Charter* have not yet been determined by the courts. One commentator suggests that, when a court is faced with these questions, all but the last issue may be answered in the affirmative. She notes that other democracies have legislation which permit the terminally ill to determine their own medical treatment and to refuse life-saving medical treatment and that that legislation is based on principles of inviolability of the person and self-determination. These values are also part of our Canadian democracy.[44] Should the courts interpret these issues in this manner, the *Criminal Code* provisions discussed above would be vulnerable to being struck down for non-compliance with the *Charter*.

D. THE NEED FOR REFORM

Many individuals wish to control the medical treatment that they will receive in the future. Under the present law, these individuals have reason to be concerned. As one commentator said:

> Advances in the field of medical science have evoked serious concern. Increasingly frequent reports of cases such as Karen Ann Quinlan's have caused many to fear the hopeless lingering before death more than death itself. This fear centers on dreaded physical incapacitation, mental incompetence, prolonged suffering, and death in the impersonal atmosphere of a hospital or nursing home. Underlying these fears is the victims' concern for the loss of power to make basic decisions regarding their care prior to death, with whom they spend their final days, and how and where they will die. In addition to these concerns regarding the loss of decisionmaking capacity, there are increasing worries that technological capabilities have moved beyond society's capacity to understand and control them.[45]

The Karen Ann Quinlan case is not an isolated example. Most people know of someone who has become incompetent to make personal medical care decisions, perhaps because of a serious illness or advanced age. Many believe that it is more appropriate for individuals to decide in advance on treatment which they want after they become incompetent to consent to or refuse treatment for themselves than for these decisions to be made by physicians by themselves or in consultation with family or friends.

Medical care decisions are thought to be too personal to be delegated to a physician or physician-family team. For example, some individuals believe that modern technology is beneficial for its ability to prolong life artificially. These persons may wish that all reasonable efforts be taken on their behalf to prolong their life. Others consider that the prolonging of life by modern technology results in a loss of dignity and extended pain and suffering. These persons may wish that medical technology capable of prolonging life be withheld from themselves in certain circumstances. The result is that competent individuals are voicing their desire to control their future personal medical care. However, in general, the present law does not provide for the legally binding expression of an individual's wishes for future medical care.

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[43] *R. v. Oakes* (1986), 26 D.L.R. (4th) 200 (S.C.C.).

[44] F. Carnerie, "Euthanasia and Self-Determinism: Is there a *Charter* Right to Die in Canada?" (1987), 32 McGill L.J. 299 at 335.

[45] J. Freeman, "Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute" (1979), 64 Iowa L. Rev. 573 at 576-577.

The present law also presents difficulties for physicians. A physician often must determine treatment for a patient who has become incompetent to consent. The responsibility is an onerous one, especially where the patient is a stranger to the physician, and there are different opinions among physicians as to whether treatment should be initiated, continued, or terminated.[46] Since treatment undertaken and subsequently interrupted may constitute a threat to life resulting in criminal consequences, and failure to take all steps to sustain or revive a person could without contrary direction from the patient constitute negligence, aggressive heroic treatment is encouraged. Physicians routinely consult with family members and secure their consent to treatment for the patient. However, even with consultation, a physician risks liability unless he or she seeks a judicial determination of incompetence and appointment of a guardian. Judicial appointments of guardians, though, are rare.[47] Notwithstanding the potential problems, the practice of 'pulling the plug' does not seem to be uncommon amongst physicians. While this practice appears to be legitimate, it has uncertain legal consequences. The end result is that physicians practise their profession with a concern for potential civil and criminal liability.[48] The problem is compounded since the fear of prosecution may have the undesirable consequence of inhibiting physicians from administering appropriate care. For example, a physician may not prescribe the appropriate or sufficient pain relief because the medication may hasten a patient's death.

Of course, there are those who oppose the very concept of persons being able to control their future medical treatment on moral or religious grounds. More specifically, they oppose the ability of individuals to refuse future life-sustaining medical treatment. Their argument on moral grounds is that "all life, regardless of the state of its existence, is sacred and deserves protection, and . . . constant vigilance must be maintained to protect those who are likely to be involuntarily eliminated or who might voluntarily but irrationally consent to die."[49] They oppose determinations of "quality" of life, believing that they are "irrelevant and precursory to the elimination of those not meeting societal norms."[50] They are particularly concerned that allowing individuals to refuse future life-sustaining treatment when they are terminally ill will lead to society accepting the attitude that some lives are not worthy of living. Over time, they fear that society might come to accept the withdrawal of medical treatment from the aged, physically or mentally handicapped and insane persons under the guise of merciful or benevolent termination. They also fear mistaken diagnoses and hold out hope for cures for what are now incurable illnesses. However, those who argue in favour of the need for individuals to be able to determine their own treatment firmly believe that the political structure of a democracy will serve to uphold the sanctity of all lives and will prevent the scenario just mentioned. In addition, the debate that surrounds the propriety of judging 'quality' of life really centres on the issue of active euthanasia (that is, positive steps taken to terminate life) rather than the need for individuals to direct their future medical treatment after they are incompetent to give directions on medical care. As one commentator said:

> Philosophical disagreements seem much less pronounced in discussions of the right of individuals who are suffering from incurable diseases accompanied by severe pain and who possess a rational

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[46]J.J. Lombard, Jr. (Coordinator) and J.L. Miller, R.E. Gother and R.N. Houghton (Moderators), "Legal Problems of the Aged and Infirm - The Durable Power of Attorney - Planned Protective Services and the Living Will" (1978), 13 Real Prop. Prob. & Tr. J. 1 at 33.

[47]M. Fowler, "Appointing an Agent to Make Medical Treatment Choices" (1984), 84 Colum. L. Rev. 985 at 994.

[48]J.G. Strand, "The 'Living Will': The Right to Death with Dignity?" (1976), 26 Case W. Res. L. Rev. 485 at 491-502.

[49]J. Freeman, "Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute" (1979), 64 Iowa L. Rev. 573 at 580.

[50]J. Freeman, "Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute" (1979), 64 Iowa L. Rev. 573 at 580-581.

and fixed desire to face their inevitable deaths to authorize the removal of extraordinary care voluntarily.[51]

Similarly, the debate on religious grounds really centres around the issue of active euthanasia. For example, while both the Roman Catholic Church and Jewish faith oppose active euthanasia, neither opposes the discontinuance of extraordinary medical treatment to a terminally ill patient.[52] Thus, although disagreements exist, there appears to be strong support for the ability of individuals to determine their future medical treatment, including the ability to refuse future life-prolonging treatment.

There is also debate as to whether legislation is needed to solve these problems. Some legal commentators believe that patient, health care and societal objectives can be achieved without legislation.[53] In their opinion, at present, without legislation, a competent patient by means of written instructions can persuade a physician to honour his or her wishes for future treatment, for example, to discontinue futile treatment efforts.[54] In addition, some fear that legislation could encourage a shift in decision-making away from the patient and family towards the physician: "The very fact that a law is deemed necessary to assure patients' rights implies, and therefore tends to reinforce, an erroneous presupposition about the locus of decision-making in the physician/patient relationship."[55] Furthermore, legislation would necessitate agreement on concepts such as terminal illness and heroic measures, matters on which there is widespread disagreement. Legislation also might lead physicians to use aggressive treatment measures on patients who have not communicated their wishes for future treatment. As well, it is feared that physicians and patients might be less flexible in their decision-making and physicians might adopt a less personal, more legalistic approach to their relationships with their patients. For these reasons, one commentator suggests that present problems might be better solved through education, review of current practices and increased availability of palliative care services.[56]

In light of this discussion, we seek opinions on the following threshold question: Should the law be reformed to permit the creation of a mechanism which would give legally binding effect to the wishes of a person not competent to make decisions about medical treatment which were expressed at a time when he or she had such competence?

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[51]J. Freeman, "Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute" (1979), 64 Iowa L. Rev. 573 at 582.

[52]J. Freeman, "Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute" (1979), 64 Iowa L. Rev. 583-584.

[53]R. Gillon, "Living wills, powers of attorney and medical practice" (1988), 14 J. Med. Ethics 59; J.J. Lombard, Jr. (Coordinator) and J.L. Miller, R.E. Gother and R.N. Houghton (Moderators), "Legal Problems of the Aged and Infirm - The Durable Power of Attorney - Planned Protective Services and the Living Will" (1978), 13 Real Prop. Prob. & Tr. J. at 27; C.A. Mooney, "Indiana's Living Wills and Life-Prolonging Procedures Act: A Reform Proposal" (1984), 20 Ind. L. Rev. 539 at 546: "There has been almost no court activity involving living wills. There are only two reported cases, both of which were decided in jurisdictions without living will legislation at the time of the decisions. Both courts stated that a patient's living will is persuasive evidence of the incompetent person's intent and should be given great weight."

[54]Law Reform Commission of Canada, *Sanctity of Life or Quality of Life* (Study Paper, 1979) 179-183; P.H. Wilson, Jr., "The Living Will - Death with Dignity or Mechanical Vitality" (1979), 10 Cum. L. Rev. 163; S.R. Akers, "The Living Will: Already a Practical Alternative" (1977), 55 Tex. L. Rev. 665 at 717.

[55]Law Reform Commission of Canada, *Sanctity of Life or Quality of Life* (Study Paper, 1979) 181, quoting R. McCormick and A. Hellegers, "Legislation and the Living Will", *America*, March 12, 1977, 211.

[56]R.H. Fisher, "Should living wills be legalized?" (1990), 142 Can. Med. Assoc. J. 23 at 25-26; see also, P.H. Wilson, Jr., "The Living Will - Death with Dignity or Mechanical Vitality" (1979), 10 Cum. L. Rev. 163 at 203 *et seq.*

E. OPTIONS FOR REFORM

In the preceding sections, we discussed the present law and its problems and asked whether the law should be reformed. In this section (and the following Chapter), we will assume that the answer to this question is in the affirmative and we will set out two mechanisms for achieving this goal: the advance directive and the durable power of attorney for health care. In the subsections which follow, we will describe each of these instruments, their benefits and limitations.

1. Advance Directive

An advance directive is a device which allows a person to communicate his or her wishes for future medical treatment in a legally binding manner. The patient's physician may be bound by legislation to follow the patient's wishes as set out in the directive (rather than provide treatment which he or she considers to be best for the patient or treatment which others believe the patient would have wanted) or refer the patient to a physician who will. In other words, the advance directive supports self-determination by allowing a patient rather than physicians or physician-family teams to decide on his or her future medical care.

The advance directive provides other advantages too. During an illness, a patient may be more easily influenced by his or her relatives, physicians, or financial considerations. The advance directive allows a patient to make decisions about his or her future medical care before becoming ill, when he or she is uninfluenced by stresses connected with the illness. The use of advance directives can also avoid court proceedings which are taken when relatives and physicians disagree on treatment and which are theoretically necessary whenever treatment decisions must be made for an incompetent adult. Not only are legal costs saved, but delays of treatment are avoided, unwanted treatment need not be administered pending court resolution and the courts need not intervene in the private field of personal health care when advance directives are used.

However, the use of advance directives is not without difficulties. The impossibility of predicting one's future medical problems and the uncertainty of prognosis of an existing medical problem make it impossible for a person to contemplate every treatment choice and provide instructions regarding them. Because the advance directive often attempts to address problems not yet in existence, the maker of an advance directive arguably may not be adequately informed: that is, he or she may not give a truly informed consent to the treatment which is directed in the document. Furthermore, the wording in advance directives must necessarily be non-specific and as such may be somewhat ambiguous. As one commentator stated, the "imprecise terminology used in most living wills leaves open questions, such as whether the patient's condition makes the declaration [advance directive] operative and whether the proposed treatment is the type that the declarant wished to have withheld."[57] While this problem can be alleviated by greater specificity, interpretation by a person familiar with the patient's wishes and discussion between the competent patient and his or her physician, a person's ability to be specific about his or her wishes for future unknown treatment has its limits and persons who are familiar with the patient's wishes and even the patient's personal physician may be unavailable to interpret the document.

In addition, the present use of advance directives is quite limited. In jurisdictions which authorize advance directives by legislation, they are generally used only to refuse life-sustaining treatment in the event that a person is in a terminal condition and unable to make medical

[57] C.A. Mooney, "Indiana's Living Wills and Life-Prolonging Procedures Act: A Reform Proposal" (1984), 20 Ind. L. Rev. 539 at 545.

treatment decisions. For example, Maine's *Living Wills Act* provides this suggested form for an advance directive:

DECLARATION

If I should have an incurable or irreversible condition that will cause my death within a short time, and if I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

Signed this _____ day of _____ _____.
date month year

Signature_____

City, County and State of Residence_____[58]
city county state

Only Maryland, Minnesota and Indiana legislation specifically provide that an advance directive may be used to direct the administration of life-sustaining procedures. For example, Maryland's legislation provides that: "An individual . . . in lieu of a declaration directing the withholding or withdrawal of life-sustaining procedures, may execute a declaration directing the initiation or continuation of life-sustaining procedures in accordance with standard medical practice."[59] Arkansas and New Mexico extend the use of advance directives only somewhat beyond terminally ill patients to patients who are permanently unconscious.

In short, although directives are said to be an aid to patient self-determination, they have proven to be so only in limited circumstances. As presently implemented, in most jurisdictions advance directives do not address the concerns of patients who want treatment that prolongs the dying process or who prefer a certain type of treatment over another; they generally address only the needs of the terminally ill, not the chronically ill.

Several studies have examined physicians' attitudes toward advance directives. The results of one study show that advance directives have not significantly affected the way physicians treat hopeless patients: physicians continue to make treatment decisions on the basis of physician-family-patient consensus, their fears of civil or criminal liability and their moral, medical or ethical treatment preferences rather than on the basis of patient wishes in advance directives.[60] Most physicians said that they would not withdraw treatment pursuant to an advance directive in the face of family disagreement even if continued treatment was futile. Physicians were not reassured by legislative provisions which provide immunity from civil or criminal liability to health professionals who rely on a directive that is properly executed. Most simply did not believe that their actions would be protected, while others went further and indicated that only a court order would convince them to withdraw care from a comatose patient. In addition, many physicians believe that they are so familiar with their patients' wishes that they do not need a directive. Because of these responses, the study concluded that advance directives likely do not have a great potential for resolving the medical decision-making problems of

[58]Maine, §2922 (Part 1 of Appendix A). Full citations for American statutes which authorize advance directives are listed in Part 1 of Appendix A, citations for American statutes which authorize durable powers of attorney for health care are listed in Part 2 of Appendix A, and citations for Australian and Canadian legislation which authorize advance directives or durable powers of attorney for health care are listed in Part 3 of Appendix A.

[59]Maryland, §5-611.

[60]J.M. Zinberg, "Decisions for the Dying: An Empirical Study of Physicians' Responses to Advance Directives" (1989), 13 Vt. L. Rev. 445.

hopeless patients even if physicians' fears of liability are eliminated and patient and physician awareness of advance directives is increased. The study also concluded that directives offer only a small informed minority an opportunity to obtain some control over their medical care while incompetent and that it may be more realistic to accept that sometimes it is socially and morally acceptable to permit another person to make treatment decisions rather than to ensure the exercise of the incompetent's right of self-determination.

The authors of a second study came to a different conclusion. They were impressed by the extent and depth of physician support of advance directives and found that those "physicians who had employed advance directives in critical situations . . . had overwhelmingly positive feelings toward their use". They concluded that this correlation provided "strong evidence that advance directives succeed in accomplishing their intended purposes."[61]

Notwithstanding the limitations of advance directives, the enactment of legislation legalizing them has mushroomed, mostly in the United States. Since 1976, 39 American states and the District of Columbia,[62] as well as three jurisdictions in Australia[63] have enacted legislation on advance directives. No Canadian jurisdiction has legislation on advance directives.

2. Durable Power of Attorney for Health Care

While enabling legislation for advance directives is becoming widespread, it seems that these instruments have had only limited success in addressing the desire for control over medical care by persons who become incompetent. In this section, we will examine another device which is gaining recognition as an aid to self-determination of medical care for persons who become incompetent to give medical consent, the durable power of attorney for health care.

At common law, a power of attorney permits a person (the principal) to authorize another person (the attorney)[64] to act as an agent in the management of his or her property affairs. The power terminates when the principal becomes mentally incompetent.[65] In Manitoba, *The Powers of Attorney Act*[66] extends the common law power so that an attorney can make decisions on property matters for the principal after the principal becomes incompetent. Similar legislation is enacted throughout Canada and the United States. In 25 jurisdictions in the United States, the power of attorney has been further extended by legislation which authorizes a principal to appoint an attorney to make personal decisions such as medical treatment decisions for himself or herself, after the principal becomes incompetent. In Canada, only Nova Scotia has enacted legislation of this sort. The Australian Capital Territory has also recently amended its durable power of attorney legislation to provide for this.

The power to make health care decisions for a principal after the principal becomes incompetent is commonly called a durable power of attorney for health care. This device has

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[61]K.W. Davidson, C. Hackler, D.R. Caradine, R.S. McCord, "Physicians' Attitudes on Advance Directives" (1989), 262 J.A.M.A. 2415 at 2419.

[62]Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

[63]Northern Territory, South Australia and Victoria.

[64]"Attorney" in this Paper simply means an agent. It does not mean a lawyer.

[65]*Drew* v. *Nunn* (1879), 4 Q.B.D. 661 (C.A.).

[66]*The Powers of Attorney Act*, C.C.S.M. c. P97. This statute was enacted pursuant to the recommendations of the Manitoba Law Reform Commission in its Report on *Special, Enduring Powers of Attorney* (Report #14, 1974).

several advantages. It allows a person incapable of expressing his or her wishes for medical treatment to do so through a person whom he or she has chosen presumably because of a belief that that person's decisions will reflect his or her own wishes and values. At the same time, the principal can displace as substitute decision-makers persons whom he or she does not trust, who could otherwise seek guardianship of the principal after he or she becomes incompetent.[67] This allows the principal to prevent decisions on future medical care being made by a person with whom he or she does not share similar values.

The durable power of attorney for health care can also be very flexible. The attorney can

> . . . make decisions not only about life-sustaining treatment, but also about other forms of treatment. The medicine, food, and fluids specifically excluded by . . . [advance directive legislation] could be controlled by the agent. In addition, because the patient need not be terminally ill before the agent could effectuate the patient's preferences, the agent would not necessarily be limited to effecting the patient's preferences in situations in which the patient was terminally ill.[68]

This is not to say that all durable powers of attorney for health care as presently enacted are this flexible. The legislation in some jurisdictions restricts the authority of attorneys to decisions regarding the withholding or withdrawal of life-sustaining treatment for incompetent principals in terminal conditions. The legislation in the Australian Capital Territory is restrictive in a different way: it authorizes attorneys to consent only to medical treatment which is necessary for the well-being of the principal. A more detailed discussion of this issue will be provided later in Chapter 3 of this Discussion Paper.

The process by which an attorney under a durable power of attorney for health care makes decisions regarding the principal's health care closely resembles that of informed consent. The attorney engages in the same decision-making process that the patient would if he or she were able.[69] That is, the attorney makes decisions on the basis of specific knowledge of the principal's condition, available treatments, instructions from the principal in the power of attorney, additional information concerning the principal's wishes, as well as the physician's recommendations. As such, the decision which an attorney makes is an informed one and, therefore, is likely to be a better decision than one made in the absence of this information (as is often the case with an advance directive). At the same time, a principal need not try to anticipate every potential medical circumstance and treatment. A durable power of attorney for health care also avoids the interpretation problems of advance directives.[70]

Medical care givers can also be certain of who is legally authorized to consent to medical treatment for the patient. They need not force a patient's family to apply to court for an order of guardianship (a process that is not often initiated) nor do they need to feel compelled to obtain consensus among family members before proceeding with treatment. Of course, a decrease in court applications is beneficial for all concerned: legal costs are saved, delays in treatment are avoided, unwanted treatment need not be administered pending court resolution and families are spared the stresses of legal proceedings in what is considered to be a private matter.[71]

Finally, an attorney can do more than instruct physicians on treatment: he or she can also ensure that the instructions are not disregarded or forgotten. This availability to argue actively

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[67]B.M. Dickens, "Decision-making in Terminal Care: The Days of One's Life and the Life of One's Days" (1986-87), 51 Sask. L. Rev. 1 at 13-14; D.A. Peters, "Advance Medical Directives" (1987), 8 J. Legal Med. 437 at 451.

[68]S. Morgan, "Selecting Medical Treatment: Does Arizona's Living Will Statute Help Enforce Decisions?", [1986] Ariz. St. L.J. 275 at 305.

[69]M. Fowler, "Appointing an Agent to Make Medical Treatment Choices" (1984), 84 Colum. L. Rev. 985 at 1001.

[70]D.A. Peters, "Advance Medical Directives" (1987), 8 J. Legal Med. 437 at 451-452.

[71]M. Fowler, "Appointing an Agent to Make Medical Treatment Choices" (1984), 84 Colum. L. Rev. 985 at 1004.

for the principal's preferences helps to guarantee that the principal's wishes will be fulfilled.[72] Of course, this assumes that the attorney is a person who can effectively argue on behalf of the principal's wishes.

The durable power of attorney for health care also has some disadvantages. An attorney may be unable or unwilling to act on behalf of the principal when he or she is needed. It is also possible that an attorney could make a decision which is inconsistent with the principal's wishes or even an irrational decision that needlessly endangers the principal. Of course, this problem is not confined to attorneys; bad decisions might be made by a family-physician team or by a court-appointed guardian. In fact, improper decisions might be less likely to be made by an attorney who is chosen by the principal, because this person is more likely to be aware of the principal's wishes and values, to have the best interests of the principal at heart and to be willing to work hard to ensure that the principal's wishes are followed.

Another disadvantage is that there may be a tendency for a physician to classify a patient too quickly as incompetent to provide consent where that patient refuses treatment that the physician believes is appropriate or where the patient demands what the physician considers to be inappropriate treatment. The physician may believe that an attorney will provide the necessary consent and be tempted to turn to him or her rather than to the patient for that consent. In addition, there may be a long time period between the appointment of an attorney and the need for his or her services and during this period a principal's choice of attorney may change. Although a principal could revoke the original appointment and appoint someone else, he or she may procrastinate and not do so. As such, great care must be taken in the initial selection. Finally, a durable power of attorney for health care is obviously not helpful to someone who has no one upon whom he or she can depend to serve as attorney.

F. CONCLUSION

Advance directives and durable powers of attorney for health care have both advantages and disadvantages. The advance directive allows an individual to instruct his or her physician as to future medical care, but its inherent lack of specificity can result in problems of interpretation. The durable power of attorney for health care allows an individual indirectly to instruct his or her physician on future medical care. Its effectiveness depends on the attorney: he or she must be able to argue effectively on behalf of the principal. One commentator suggests that advance directives together with durable powers of attorney for health care may provide the best solution. The advance directive can act as a guide for the attorney and, if the attorney is unable or unwilling to act, the directions in the advance directive can be followed.[73]

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[72]S. Morgan, "Selecting Medical Treatment: Does Arizona's Living Will Statute Help Enforce Decisions?", [1986] Ariz. St. L.J. 275 at 306; D.A. Peters, "Advance Medical Directives" (1987), 8 J. Legal Med. 437 at 451.

[73]M. Lankfer, "Living Wills and Durable Powers Authorizing Medical Treatment Decisions", [1985] Mich. B.J. 684 at 689.

CHAPTER 3

ISSUES OF IMPLEMENTATION

At the end of the preceding Chapter, we described advance directives and durable powers of attorney for health care. Assuming that legislation should be enacted to give legal effect to one or both of these instruments, we now consider issues relating to their implementation.

A. SCOPE

Given that advance directives and durable powers of attorney for health care directly convey or authorize an attorney to convey an individual's wishes for medical treatment after he or she is no longer able to communicate them, it is appropriate that a basic requirement for an advance directive to become effective or an attorney to become empowered to make health care decisions should be that an individual be unable to communicate his or her wishes for medical treatment.

However, in addition to this requirement, most statutes which authorize advance directives or durable powers of attorney for health care require that the individual must have a terminal condition.[1] Moreover, it is apparent from the wording of many statutes which authorize advance directives and durable powers of attorney for health care that legislators contemplated the primary use of these instruments as the refusal of life-prolonging medical treatment. For example, Utah's *Personal Choice and Living Will Act* provides:

> (1) The Legislature finds:
>
> (a) developments in medical technology make possible many alternatives for treating medical conditions and make possible the unnatural prolongation of death;
>
> (b) terminally ill persons should have the clear legal choice to be spared unwanted life-sustaining procedures, and be permitted to die with a maximum of dignity and a minimum of pain; and
>
> (c) considerable uncertainty exists in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures, even when a person in a terminal condition has evidenced a desire that the procedures be withheld or withdrawn.
>
> (2) In recognition of the dignity and privacy which all persons are entitled to expect, and to protect the right of individuals to refuse to be touched or treated in any manner without their willing consent, the Legislature declares that this state recognizes the right to make binding written directives instructing physicians and other providers of medical services to withhold or withdraw, or to provide only to the extent set forth in a directive, life-sustaining and other medical procedures.[2]

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[1]Terminal condition is defined differently in different jurisdictions. It is defined in some jurisdictions as "a condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty . . . there can be no recovery . . . and . . . death will occur from the terminal condition within a short period of time without the provision of life-prolonging procedures": Indiana, §16-8-11-9; and in others as an "incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time: Arkansas, §1(9); National Conference of Commissioners on Uniform State Laws, *Uniform Rights of the Terminally Ill Act* (hereinafter referred to as the *Uniform Act*), 1985, s. 1(9).

[2]Utah, §75-2-1102.

The reason for legislation being so narrowly focused is that legislators intended to address only the concern that modern medical techniques might be used to keep terminally ill patients alive when they can no longer communicate their wishes that life-prolonging medical treatment be terminated.

Restricting the use of advance directives and durable powers of attorney for health care to the refusal of treatment by terminally ill individuals rules out their use in many other circumstances where they would assist.[3] Indeed, the case of Karen Ann Quinlan, which prompted the enactment of advance directive legislation in the United States and elsewhere provides an example.[4] Karen Ann Quinlan lived for over ten years in a permanent state of unconsciousness. Had she executed an advance directive while competent, in most jurisdictions which authorize advance directives, her directive would have been ineffective since she was not terminally ill. Only Arkansas and New Mexico have addressed this inadequacy by enacting legislation which allows advance directives to be effective for an individual who is permanently unconscious or terminally ill.[5]

Victoria (Australia) legislation limits the use of advance directives in a different manner: it authorizes an individual to refuse medical treatment generally or treatment of a particular kind but only for a current condition. The refusal becomes invalid if the individual's medical condition changes from the current condition. California's legislation is similarly restrictive: advance directives must be executed at least 14 days after the individual is diagnosed and certified (in writing) by two physicians to be afflicted with a terminal condition.

Also ignored by many statutes which authorize advance directives or durable powers of attorney for health care are individuals who want to communicate a consent rather than a refusal of future medical treatment. An individual might wish to consent to the administration of life-prolonging treatment or perhaps to treatment which is recommended by standard medical practice. Advance directives and durable powers of attorney for health care could serve as vehicles for communicating such a consent to future medical treatment. Allowing these instruments to be used for this purpose would encourage their more widespread use and would more closely accord with the principles of autonomy and self-determination. The legislation in Illinois, Nevada, Vermont, Nova Scotia and the Australian Capital Territory provides for this type of wider application for durable powers of attorney for health care. Similarly, legislation in Maryland, Minnesota and Indiana provides that an advance directive may be used to direct the administration of life-sustaining procedures.[6]

Whether an individual should be able to direct that artificial nutrition and hydration be withheld or withdrawn pursuant to an advance directive or a durable power of attorney for health care is a controversial issue. Those opposed argue that artificial nutrition and hydration comprise basic nursing care (or 'comfort care') much like personal hygiene and pain control does and, as such, should be excluded from treatment which can be withdrawn or withheld. Others argue that artificial feeding and hydration is not necessarily basic nursing care, that sometimes it

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[3]L.L. Heintz, "Legislative hazard: keeping patients living, against their wills" (1988), 14 J. Med. Ethics 82 at 83 *et seq.*; G. Gelfand, "Living Will Statutes: The First Decade", [1987] Wis. L. Rev. 737 at 746-747. Besides seriously impairing the use of advance directives and durable powers of attorney for health care, the requirement of terminal illness may also be unconstitutional. In the United States, the right to refuse or consent to treatment is a fundamental right which needs no one's approval and its restriction is contrary to common law, principles of medical ethics and federal and state Constitutions. Similar arguments might be made in Canada since the right to refuse or consent to treatment is also part of our common law.

[4]*In re Quinlan*, 355 A.2d 647 (N.J. 1976).

[5]"Permanently unconscious" is defined in Arkansas' Act as "a lasting condition, indefinitely without change in which thought, feeling, sensations and awareness of self and environment are absent": Arkansas, §1(11). See Appendix B, which contains statutory forms suggested in Arkansas' legislation.

[6]See Appendix B, which contains the Life-Prolonging Procedures Declaration provided by Indiana's legislation.

merely prolongs the dying process and that physicians should be permitted to withhold or withdraw it in these cases. The National Conference of Commissioners on Uniform State Laws in the United States holds the latter view. As the comment to the *Uniform Act* states:

> The purpose for permitting continuation of life-sustaining treatment deemed necessary for comfort care or alleviation of pain is to allow the physician to take appropriate steps to insure comfort and freedom from pain, as dictated by reasonable medical standards . . . . If nutrition and hydration are not necessary for comfort care or alleviation of pain, they may be withdrawn.[7]

Finally, others argue that the provision of artificial nutrition and hydration cannot be distinguished from the provision of other medical treatment[8] and that its withdrawal should be based on the same criteria as other medical treatment: it should be withheld or withdrawn on the basis of patient wishes rather than the type of treatment or patient prognosis.[9] In the United States, these three positions on the withdrawal and withholding of artificial nutrition and hydration are evident in the legislation which authorizes advance directives: some statutes specifically prohibit the withholding or withdrawal of artificial nutrition and hydration;[10] other statutes allow artificial nutrition and hydration to be withheld or withdrawn[11] and the remaining statutes allow only nutrition and hydration which is not necessary for patient comfort and care to be withheld or withdrawn.[12] Victoria's legislation bars the refusal of palliative care, which it defines as "the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or . . . the reasonable provision of food and water."[13]

Whether every medical treatment can be administered pursuant to a direction in an advance directive or durable power of attorney for health care must also be addressed. For example, can palliative care which may shorten an individual's life be administered pursuant to one of these instruments? This is debatable given that public policy dictates that no one can take positive steps to shorten another individual's life. As mentioned in the preceding Chapter, a strict interpretation of the *Criminal Code* may mean that the administration of palliative treatment which shortens the life of a terminally ill patient could give rise to physicians being charged with murder. Practically speaking, given the absence of prosecutions or convictions of physicians in Canada for murder in those circumstances and public support for the use of pain-relieving medication to relieve suffering in terminally ill patients, physicians probably need not worry. Nonetheless, we note the recommendation of the Law Reform Commission of Canada that the

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[7] *Uniform Act*, comment to §6.

[8] American Medical Association, "Withholding or Withdrawing Lifeprolonging Medical Treatment. Opinion of the AMA Council on Ethical and Judicial Affairs" (1986), as referred to in C.J. Condie, "Comparison of the Living Will Statutes of the Fifty States" (1988), 14 J. Contemp. L. 105 at 121; E.M. Joyce, "To Die or Not to Die: The New York Legislature Ponders a Natural Death Act" (1985), 13 Fordham Urb. L.J. 639 at 649-650 and 674, referring to *In re Conroy*; R. Steinbrook and B. Lo, "Artificial Feeding - Solid Ground, not a Slippery Slope" (1988), 318 N. Eng. J. Med. 286 at 288.

[9] R. Steinbrook and B. Lo, "Artificial Feeding - Solid Ground, not a Slippery Slope" (1988), 318 N. Eng. J. Med. 286 at 288; American Academy of Neurology, *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient* (1988).

[10] Colorado, Connecticut, Florida, Georgia, Missouri and Wisconsin.

[11] The advance directive legislation in Alaska, Arkansas, Idaho, Minnesota, New Mexico and Tennessee specifically permits the withholding or withdrawal of artificial feeding and hydration (in Arkansas, Idaho and Minnesota the statutory form actually provides for a choice to be made between accepting or rejecting artificial feeding and hydration; in Tennessee an individual can direct the withholding or withdrawal of artificial or forced feeding but this does not "allow the withholding of simple nourishment or fluids so as to condone death by starvation of dehydration."(§32-11-103(5)). Since the legislation in Alabama, California, Delaware, District of Columbia, Kansas, Louisiana, Mississippi, Montana, Nevada, North Carolina, Oregon, Texas, Vermont, Virginia and Washington makes no specific reference to the withholding or withdrawal of artificial nutrition or hydration, the legislation might be interpreted to permit it.

[12] Arizona, Arkansas, Hawaii, Indiana, Iowa, Maryland, New Hampshire, Oklahoma, South Carolina, West Virginia, and the *Uniform Act*.

[13] Victoria, s. 3.

Criminal Code should be amended to exempt the administration of palliative care from the definition of murder.[14] Other procedures such as commitment or placement of an individual in a mental health treatment facility, convulsive treatment, psycho-surgery, sterilization and abortion are highly controversial procedures. No doubt because of the controversial nature of these procedures, five American jurisdictions have prohibited attorneys from consenting to them on behalf of their principals.[15]

Some critics worry that legislation which legalizes advance directives and durable powers of attorney for health care might lead to the belief that these instruments can be used to direct others to cause or accelerate death. To avoid any problems of interpretation, enabling legislation could specifically prohibit the use of these instruments for this purpose. In fact, most American legislation which authorizes advance directives as well as South Australia's and the Northern Territory's legislation distinguishes between acts which cause or accelerate death and acts which permit the dying process to take its natural course, authorizes these instruments to be used only for the latter purpose and prohibits their use for instructing others to cause or accelerate an individual's death.[16]

On the other hand, whether an individual or an attorney on behalf of an individual should be permitted to insist on obtaining heroic treatment in every circumstance is not usually addressed in legislation which authorizes advance directives or durable powers of attorney for health care. In part, this is attributable to the fact that no one is automatically entitled to receive heroic treatment. Because it is often scarce and expensive, the provision of heroic treatment is governed by its availability and the needs of the individual as compared to other individuals in the community; if the needs of others outweigh the needs of an individual who requests heroic measures, that individual cannot receive the requested treatment. However, even if heroic measures are available, an individual who does not need heroic measures cannot insist on receiving them. For example, a person cannot insist on being placed on an artificial life-support system when he or she does not need its support to live. To make sure that individuals are aware of their rights with respect to the provision of heroic treatment, it may be advisable that an amendment be made to the *Criminal Code* (as was recommended by the Law Reform Commission of Canada) to clarify that a physician is not obliged to provide or continue medical treatment which is therapeutically useless[17] and will not benefit a patient, simply because the patient requests the care.

Another highly controversial issue is whether a refusal of life-prolonging treatment in an advance directive or a refusal by an attorney on behalf of a principal pursuant to a durable power of attorney for health care should be honoured where the patient is a pregnant woman. The controversy arises because a refusal of life-prolonging treatment in those circumstances affects not only the woman's life but also the life of the foetus. As such, a pregnant woman's refusal of life-prolonging treatment sets up a conflict between a woman's right to determine her medical treatment and the right of the foetus to be protected, a right which is not clearly defined.

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[14]Law Reform Commission of Canada, *Recodifying Criminal Law* (Report #31, 1987) 60. The Commission's recommendation was that the following provision be added to the *Criminal Code*:

> Palliative Care. Clauses 6(1) to 6(5) [pertaining to murder, manslaughter, homicide and suicide] do not apply to the administration of palliative care appropriate in the circumstances for the control or elimination of a person's pain and suffering even if such care shortens his life expectancy, unless the patient refuses such care.

[15]California, Illinois, Nevada, Rhode Island and Vermont.

[16]South Australia, Northern Territory.

[17]Law Reform Commission of Canada, *Recodifying Criminal Law* (Report #31, 1987) 20. The Commission recommended that the following exception be made to the duty of everyone to "take reasonable steps, where failure to do so endangers life, to . . . provide necessaries to . . . anyone under his care if such person is unable to provide himself with necessaries of life . . . [and] carry out an undertaking he has given or assumed . . .": "Medical Treatment Exception. No one has a duty to provide or continue medical treatment which is therapeutically useless or for which informed consent is expressly refused or withdrawn."

If a refusal of life-prolonging treatment by a pregnant woman is honoured without regard to the pregnancy, her wish to determine her medical treatment would be respected while the welfare of the foetus would be completely ignored. Depending on the stage of development of the foetus, the foetus could die. This would obviously conflict with the fact that historically, "the foetus has always been protected to some extent" although it "has not been viewed as having the rights of a person in the full sense".[18] If, on the other hand, no effect is given to a refusal of life-prolonging treatment by a pregnant woman, the possibility of life for the foetus may be safeguarded but at the expense of the woman's personal dignity, bodily integrity and autonomy. Even if the latter approach is preferred, safeguarding the foetus' possible survival in every case at the expense of a woman's personal rights may be inappropriate. For example, where the foetus is in the early stages of development, it may have little, if any, chance of survival, especially when the pregnant woman has sustained severe injury. In addition, maintaining the pregnant woman on a life-support system might be more harmful to the health of the foetus than allowing the foetus to try to survive on its own if medications or treatment necessary for the woman are toxic to the foetus. A compromise between the rights of the woman and protection of the foetus might be achieved if a pregnant woman's refusal of life-sustaining treatment were not honoured when it is probable that the foetus could develop to live birth with the administration of life-sustaining treatment to the pregnant woman, but honoured where the foetus is unlikely to survive where the woman is maintained on life-support systems.

A recent American case has addressed the issue of maternal versus foetal rights. The District of Columbia Court of Appeals stated: "We hold that in virtually all cases the question of what is to be done is to be decided by the patient - the pregnant woman - on behalf of herself and the fetus."[19] The case involved a terminally ill woman who was 26 weeks pregnant. The Court stated that, rather than balancing the woman's rights against the interests of the State (in this case the survival of the foetus), the lower court should have tried to determine the woman's treatment wishes. Whether Canadian courts will take this approach remains to be seen.

Any restriction on a pregnant woman's determination of future medical care is complicated by the fact that such a restriction would also limit her access to abortion. In the United States, a woman has a constitutional right to an abortion in the early stages of pregnancy; as such, restricting a pregnant woman's ability to refuse life-prolonging treatment in an advance directive or the ability of an attorney to refuse life-prolonging medical treatment on her behalf may be unconstitutional. Constitutional challenges have been instituted against American legislation which restricts the effectiveness of advance directives of pregnant women[20] but, to our knowledge, decisions have not yet been reached in these cases; time will tell whether American provisions which restrict a pregnant woman's right to refuse life-prolonging medical treatment in an advance directive or durable power of attorney for health care will be struck down. In Canada, access to abortion may be protected by the *Charter*. Section 7 of the *Charter* which protects the "right to liberty" has been interpreted to protect the right to "a degree of autonomy in

[18] *Tremblay* v. *Daigle* (1989), 62 D.L.R. (4th) 634 at 661 (S.C.C.). The Court indicated that "[t]o enjoy rights, a foetus must be born alive." The Court's basis for this comment was the historical treatment of abortion in Canada: it "has not generally been considered equivalent to murder in our laws. . . ."

[19] "Court backs pregnant women", *The Globe and Mail* (Nat. ed.), April 27, 1990, A5, referring to the Angela Carder case, District of Columbia Court of Appeals, April, 1990.

[20] In some states, the advance directive of a pregnant woman is invalid during her pregnancy: Connecticut, Delaware, Florida, Georgia, Hawaii, Indiana, Kansas, Maryland, Mississippi, Nevada, Texas, Utah, Washington and Wisconsin. In others, it is invalid only where it is possible for the foetus to develop to the point of live birth with continued application of life-sustaining procedures: Alaska, Arizona, Arkansas, California, Illinois, Iowa, Minnesota and Montana. In South Australia and the Northern Territory, the legislation provides that the Act does not prevent "the artificial maintenance of the circulation or respiration of a dead person . . . where the dead person was a pregnant woman - for the purpose of preserving the life of the foetus.": South Australia, s. 7(1)(b); Northern Territory, s. 7(1)(b).

making decisions of fundamental personal importance."[21] Whether this provision protects a pregnant woman's right to refuse life-prolonging treatment is not yet determined.

No doubt too, someday, Canadian courts will be asked to determine whether a father is entitled to prevent a pregnant woman's refusal of life-sustaining treatment. One commentator suggests that in the United States a father may have this right.[22] However, in Canada, the Supreme Court of Canada has indicated that a father's interest in a foetus which he helped to create is insufficient to support a right to veto a woman's decisions in respect of the foetus she is carrying.[23] This suggests that, in Canada, a potential father may not have the right to prevent a pregnant woman from refusing life-sustaining treatment.

In conclusion, the scope of advance directives and durable powers of attorney for health care greatly influences their usefulness. The broader their scope, the more frequently they will be used and the greater will be an individual's ability to determine his or her future medical treatment while incompetent. However, some limitations on their use may be appropriate.

B. ROLE OF PHYSICIANS AND HOSPITALS

What effect should be given to an advance directive or durable power of attorney for health care? Should these documents be treated as binding? That is, should medical care givers be required to follow the directions in the documents or the directions of the attorney? In the alternative, the directions provided in an advance directive or by the attorney could be considered merely persuasive, of great weight or presumptive evidence of the patient's desires. This approach gives control in decision-making to health care professionals: a physician could consider the directions and decide whether to follow them on the basis of other factors such as standard medical procedure and the family's wishes. Only Nevada takes this approach. Another option is that certain advance directives and durable powers of attorney for health care have binding effect while others be considered as merely indicative of the patient's wishes. Oklahoma's legislation takes this approach, for example. It provides that a directive which is executed after the onset of a terminal illness must be followed by the physician, while a directive which is executed prior to a diagnosis of terminal illness need only be considered along with other factors by the physician who can then decide whether or not to comply. Of the options just mentioned, the first is by far the most common; only it allows a person to determine fully his or her future medical treatment by providing a binding mechanism by which an individual can instruct health care professionals on future treatment. Allowing greater flexibility in decision-making to health care professionals removes the decision-making power from individuals and seems to defeat the main objective of advance directives and durable powers of attorney for health care.[24]

However, while it is arguably beneficial for individuals to control their future medical treatment, it is not fair for physicians to be forced to treat individuals against their personal beliefs or medical judgment. For example, a physician may be opposed to the withdrawal or withholding of life-prolonging medical treatment for religious or moral reasons or for the reason that, in his or her professional judgment, the treatment will genuinely benefit the patient. Instead, a physician or hospital not wishing to follow an advance directive or the direction of an attorney could be required to transfer the patient to another professional or facility who will

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[21] *Morgentaler* v. *The Queen* (1988), 44 D.L.R. (4th) 385 at 487 (S.C.C.).

[22] J. Freeman, "Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute" (1979), 64 Iowa L. Rev. 573 at 621.

[23] *Tremblay* v. *Daigle* (1989), 62 D.L.R. (4th) 634 (S.C.C.).

[24] G. Gelfand, "Living Will Statutes: The First Decade", [1987] Wis. L. Rev. 737 at 770-771.

comply with the patient's wishes. A number of American states provide for this.[25] However, sometimes transfer may be impossible. For example, a patient may be too ill to be transferred or an isolated community may have only one physician. One commentator suggests that, in these sorts of circumstances, where transfer is impossible, a patient's wishes should supersede the objections of a physician.[26] Many of the American statutes which authorize advance directives require only that a physician who will not comply with a directive make reasonable efforts to transfer the patient to a physician who will comply;[27] some require the same of a health care facility which will not comply.[28] There are a number of jurisdictions, both in the United States and elsewhere, which simply provide that medical professionals are obligated to comply with an advance directive or durable power of attorney for health care, without giving professionals the option to transfer the patient.[29] Presumably, in these jurisdictions, medical professionals have no alternative but to follow the directive or durable power of attorney for health care.

Some physicians or hospitals not wishing to honour the instructions in an advance directive or the directions of an attorney may nonetheless not make efforts to transfer a patient to a physician or hospital who will comply. To ensure that this does not happen, it may be necessary to penalize such physicians and hospitals. As one set of commentators has said:

> . . . [B]ecause the medical decisionmaker is under no threat of penalty if the Living Will is disregarded, and is given scant protection if it is followed, he has gained little incentive to follow the patient's wishes, and even greater control over sobering life and death issues.[30]

The same comment could be made with respect to durable powers of attorney for health care. Approximately half of the American states with legislation authorizing advance directives provide penalties for physicians or hospitals who do not comply with a directive or transfer the patient to a physician or hospital who will comply.[31] Victoria's legislation also prescribes a penalty for medical practitioners who knowingly treat a person contrary to a refusal as set out in the directive. Penalties range from charges of unprofessional conduct to criminal charges. However, penalties may foster adverse relations between patients and health care professionals. In addition, penalties are inappropriate where a physician or hospital does not comply with an advance directive or durable power of attorney for health care because of an uncertainty about its validity.

While penalties may provide physicians and hospitals with an incentive to follow an advance directive or an attorney's directions, they may be ineffective for physicians and hospitals apprehensive about a civil lawsuit from relatives who object to certain treatment. Those physicians and hospitals may prefer to follow the wishes of the patient's family rather than the patient's wishes (attorneys who give instructions in accordance with the principal's directions but against the family's wishes may have similar liability concerns). Obviously, if fears of civil liability for honouring an advance directive or durable power of attorney for health

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[25]Alaska, California, Colorado, District of Columbia, Hawaii, Illinois, Indiana, Kansas, Nevada, New Hampshire, New Mexico, Oklahoma, Oregon, Utah, West Virginia.

[26]R. Steinbrook and B. Lo, "Artificial Feeding - Solid Ground, not a Slippery Slope" (1988), 318 N. Eng. J. Med. 286 at 289.

[27]Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Iowa, Louisiana, Maine, Mississippi, Missouri, Minnesota, Montana, Oregon, South Carolina, Tennessee, Texas, Vermont, Virginia, Wisconsin, Wyoming and the *Uniform Act*.

[28]Alaska, Arkansas, Iowa, Maine, Minnesota, Mississippi, Missouri, Montana, Oregon and the *Uniform Act*.

[29]Connecticut, Delaware, North Carolina, Northern Territory, South Australia, Victoria and Nova Scotia - advance directives; Nevada, Rhode Island and Australian Capital Territory - durable powers of attorney for health care.

[30]S.R. Martyn and L.B. Jacobs, "Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney" (1984), 63 Neb. L. Rev. 779 at 794.

[31]Alaska, Arkansas, California, Connecticut, District of Columbia, Hawaii, Illinois, Indiana, Kansas, Maine, Maryland, Missouri, Montana, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Wisconsin and the *Uniform Act*.

care are large enough that physicians fail to honour these documents, their effectiveness will be seriously reduced. To eliminate this problem, legislation could provide that physicians, other medical care professionals and hospitals who follow an advance directive or rely on an attorney's authority (where there is no reason to suspect the document's validity or the attorney's authority) are immune from civil liability. Immunity from civil liability is guaranteed to health care professionals in all American jurisdictions authorizing advance directives, in three of the five American states which authorize the durable power of attorney for health care by a special statute,[32] as well as in South Australia's and the Northern Territory's legislation. Illinois and Vermont legislation authorizing durable powers of attorney for health care also grants immunity to an attorney who complies with the principal's directions.

In addition to civil liability, physicians may fear criminal liability for following the directions in an advance directive or the directions of an attorney who is empowered by a durable power of attorney for health care. This impediment to the effectiveness of advance directives and durable powers of attorney for health care could be removed if immunity from criminal liability were granted to physicians, other medical professionals and hospitals who in good faith comply with an advance directive or follow the instructions of an attorney. However, since criminal law is a matter of exclusive federal jurisdiction, only the federal government can amend the *Criminal Code* to provide such immunity.

C. EXECUTION

1. Qualifications for Maker and Principal

The establishment of qualifications for an individual to execute an advance directive or durable power of attorney for health care inevitably means that some persons who lack the qualifications will be excluded from executing either of these documents or, if they do, the validity of the document will be in doubt. However, qualifications fulfil the important function of helping to ensure that a person who executes either of these documents understands what he or she is executing. There are a number of bases on which an individual might have to qualify to execute either of these documents. For example, Kutner, the originator of the concept of advance directives, suggested that only persons who are neither institutionalized nor judged to be incompetent should be permitted to execute an advance directive.[33] However, many individuals might be eligible to execute an advance directive or durable power of attorney for health care on this basis and yet be incapable of understanding either of these documents. An alternative might be to require that a person be capable of providing informed consent to medical treatment, that is, be capable of understanding the nature and consequences of proposed treatment. This requirement seems appropriate given that advance directives and durable powers of attorney for health care convey a consent or refusal to future medical treatment. Nova Scotia's legislation pursuant to which an individual may authorize another person to make future medical care decisions on his or her behalf takes this approach; in order to execute the document, a person must be "capable of giving consent to medical treatment or directions respecting medical treatment".[34] On the other hand, legislation might more generally require only that a person who wishes to execute an advance directive or durable power of attorney for health care be competent. This is the approach taken by every American jurisdiction with legislation authorizing advance directives as well as the legislation in Victoria, the Northern Territory and South Australia; each requires that the maker be of sound mind.[35]

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[32]California, Illinois and Vermont.

[33]L. Kutner, "Due Process of Euthanasia: 'The Living Will, A Proposal'" (1968-69), 44 Ind. L.J. 539 at 552.

[34]Nova Scotia, s. 2.

[35]C.J. Condie, "Comparison of the Living Will Statutes of the Fifty States" (1988), 14 J. Contemp. L. 105 at 108.

Another qualification might be age. Eligibility to execute advance directives and durable powers of attorney for health care could be limited to adults. In that case, a minor who could understand the nature and consequences of proposed treatment and, therefore, who could consent to that medical treatment would nonetheless be unable to consent to the care to be administered after he or she became incompetent.

Instead of drawing an arbitrary line at some age such as 18, minors who can understand the nature and consequences of proposed treatment, that is, those who can provide consent to medical treatment, could be allowed to execute an advance directive or durable power of attorney for health care. Minors lacking the understanding to make decisions about their present medical treatment would not be permitted to execute an advance directive or durable power of attorney for health care and so would be prevented from making decisions about their future medical treatment. Although this option would be a logical extension of the existing law, it presents the problem of necessitating a determination in each case as to whether a minor has the required level of understanding of the nature and consequences of proposed treatment at the date of execution. Two suggestions have been made with respect to this determination. The first is that a document which is executed by a minor could be treated as advisory, subject to a court determination of the minor's maturity at the date of execution.[36] The second suggestion is that a minor who wishes to execute either of these documents could be required to receive counselling from his or her parents, physician or both to ensure that he or she understands the ramifications of executing the document, and that only minors who have the requisite understanding be eligible to execute a document.[37] The latter suggestion could avoid a court determination if the person who counselled the minor is required to execute a statement confirming the minor's understanding at the date of execution.

Eligibility to execute an advance directive or durable power of attorney for health care could instead be limited to minors who belong to a select group, such as minors who are living away from their parents (emancipated minors) or who are married. A provision of this sort may again prevent some minors who are mature enough to consent to their current medical treatment from deciding on their future medical treatment through the execution of an advance directive or durable power of attorney for health care. This approach can be found in other areas of Manitoba law. For example, a similar approach is taken with respect the execution of testamentary wills by minors in *The Wills Act*.[38] However, most American and Australian legislation which authorizes advance directives or durable powers of attorney for health care requires that a person who wishes to execute a directive must be an adult. Nova Scotia has the same requirement. Only Illinois explicitly allows emancipated minors to execute an advance directive.

2. Requirements of Attorneys

The effectiveness of a durable power of attorney for health care greatly depends upon the attorney's conscientious pursuit of the principal's wishes. To ensure that the attorney advocates the principal's wishes rather than his or her own preferences, limitations could be placed on who can be appointed as an attorney. It goes without saying that persons with interests adverse to the principal might be tempted to make decisions about the principal's treatment on the basis of a benefit to themselves or the principal's family rather than on the basis of the principal's wishes.

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[36] J. Freeman, "Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute" (1979), 64 Iowa L. Rev. 573 at 617.

[37] C.J. Condie, "Comparison of the Living Will Statutes of the Fifty States" (1988), 14 J. Contemp. L. 105 at 109.

[38] *The Wills Act*, C.C.S.M. c. W150, s. 8(1). That Act provides that a will which is executed by a minor is valid if the minor is or was married or is a member of the Canadian Forces at the date of execution.

Persons with interests adverse to the principal might include persons who have an interest in the principal's financial affairs or estate such as debtors, creditors or heirs; these people could benefit on the principal's death by an inheritance or the collection of a debt from the principal's estate. The principal's health care providers, employees of the health care providers or nursing home operators also may have a financial interest in continuing or discontinuing treatment to the principal. For this reason, the five American states with separate statutes authorizing durable powers of attorney for health care bar health care providers, employees of health care providers and nursing home operators from acting as attorneys.[39]

However, it is family members and friends who will pose the greater dilemma, for they will frequently be debtors, creditors or heirs of the principal. Barring them from acting as attorneys on the basis of a potential conflict of interest would effectively eliminate virtually everyone who cares about the principal.[40] As the Alberta Law Reform Institute said:

> It would be invidious to single out individuals or groups and suggest that they are untrustworthy . . . . Nor do we think that individuals should be excluded simply because they are in a position to exercise influence over the donor. In many cases such a rule would exclude the very people who are most likely to act in the donor's [principal's] best interests; for example, close relatives and friends.[41]

Most American legislation, as well as the legislation in Nova Scotia, the Australian Capital Territory and the American *Uniform Rights of the Terminally Ill Act* do not restrict persons who have conflicting interests from acting as an attorney.

The Nova Scotia Act, the *Uniform Act* and the legislation in Utah which authorizes durable powers of attorney for health care prescribe a different requirement for an attorney: these statutes all require that the attorney be an adult. The reason for this restriction is that minors have been perceived to be incapable of performing the functions of an attorney. As discussed earlier, this requirement can be seen as arbitrary; some mature minors who could be responsible attorneys would be excluded by this restriction. An alternative might be to require only that the attorney understand the nature and consequences of proposed medical treatment. However, this lacks the certainty of an age restriction.

3. Witnesses

Witnesses to the execution of an advance directive or durable power of attorney for health care fulfil several functions. First, they can help to protect the maker of a document from undue influence or fraud at the execution of the document. Second, witnesses can attest to the soundness of mind of the maker and his or her voluntary execution of the document. This provides the court with evidence of the validity of the document, should such evidence be necessary at a later date. The third function of witnesses is a cautionary one; as participants in the ceremonial process which surrounds the execution of a document, they help to impress the

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[39]California, Illinois, Rhode Island, Nevada and Vermont.

[40]S. Morgan, "Selecting Medical Treatment: Does Arizona's Living Will Statute Help Enforce Decisions?", [1986] Ariz. St. L.J. 275 at 306; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forego Life-Sustaining Treatment* (1983) 129-130. (The President's Commission was an American Commission which had a Congressional mandate to report on "the matter of defining death, including the advisability of developing a uniform definition of death": *id.*, at 9. Under this mandate, the Commission was authorized to investigate any other appropriate matter consistent with the purposes of its authorizing statute. It carried out public hearings in 4 American cities at which it heard witnesses from the fields of medicine, nursing, hospital administration, the social sciences, philosophy, theology and law as well as the testimony of patients and their families. In this report, it addressed the concerns of the treatment of patients who are dying).

[41]Alberta Law Reform Institute, *Enduring Powers of Attorney* (Report for Discussion #7, 1990) 60. It should be noted that this Report dealt only with durable powers of attorney for property matters.

maker with the importance of his or her actions and, by doing so, they help to prevent impulsive decision-making and ensure that the maker intends the document to have effect.[42] Because they fulfil these functions, the presence of witnesses at a document's execution provides some assurance to a person who must rely on a document of its validity and as a result they encourage physicians and families to honour these documents.[43]

If one witness is beneficial, is more than one witness even better? Two or more witnesses seem no more likely to deter fraud or undue influence than would one witness.[44] However, if more than one witness is required for the execution of a document, there is a greater chance that a witness will be available at a later date should it be necessary to prove the validity of the document. Two witnesses might be more appropriate than a larger number since, the larger the number required, the more likely it is that the requirements of the legislation will not always be met. With one exception, the American statutes which authorize advance directives all have a minimum requirement of two witnesses; South Carolina legislation requires three. All the Australian legislation also requires two witnesses to the execution of an advance directive or durable power of attorney for health care, while Nova Scotia's Act requires only one. Of the five American jurisdictions which have enacted special statutes authorizing durable powers of attorney for health care, four require either two individuals or a notary public to act as witnesses; Illinois legislation contains no witnessing requirements.

A more difficult issue concerns the qualifications, if any, which should govern who is eligible to act as a witness. We dealt with a related issue earlier in the context of qualifications for attorneys. Elaborate witnessing requirements are not necessarily advantageous. As the National Conference of Commissioners on Uniform State Laws stated in its comment to the *Uniform Act* (which requires only that two individuals act as witnesses):

> First, the interest in simplicity mandates as uncomplicated a procedure as possible. It is intended that the Act present a viable alternative for those persons interested in participating in their medical treatment decisions in the event of a terminal condition.
>
> Second, the absence of more elaborate witness requirements relieves physicians of the inappropriate and perhaps impossible burden of determining whether the legalities of the witness requirements have been met. Many physicians understandably and rightly would be hesitant to make such decisions and, therefore, the effectiveness of the declaration might be jeopardized. It should be noted, as well, that protection against abuse in these situations is provided by the criminal penalties. . . . The attending physicians and other health-care professionals will be able, in most circumstances, to discuss the declaration with the patient and family and any suspicion of duress or wrongdoing can be discovered and handled by established hospital procedures.[45]

On the other hand, there are cogent reasons for qualifications for witnesses. Any person who has an interest in or claim against an individual's estate or who has a financial interest in the continuation of medical treatment for an individual might be tempted in order to benefit himself or herself to force the individual to execute an advance directive or durable power of attorney for health care against his or her will. Restrictions on who can act as a witness could ensure that persons who might be tempted to exert undue influence are not given the opportunity of doing so. Ontario's Advisory Committee on Substitute Decision Making for Mentally Incapable Persons recommended a very broad range of persons to be ineligible to act as witnesses, and included in this category persons related to the principal or attorney, whether by blood, adoption or marriage, the staff of a facility where the principal is cared for and persons who are involved

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[42]Manitoba Law Reform Commission, *"The Wills Act" and the Doctrine of Substantial Compliance* (Report #43, 1980) 14-17.

[43]J.A. Robertson, *The Rights of the Critically Ill* (1983) 97.

[44]Alberta Law Reform Institute, *Enduring Powers of Attorney* (Report for Discussion #7, 1990) 41, referring to Newfoundland Law Reform Commission, *Enduring Powers of Attorney* (Report #2, 1988) 34.

[45]*Uniform Act*, comment to §2.

in litigation with the principal.[46] Most American legislation which authorizes advance directives or durable powers of attorney for health care exclude as eligible witnesses persons who have a financial interest in providing care to an individual as well as those who have an interest in or claim against an individual's estate.[47] Legislation in the Australian Capital Territory bars the attorney and relatives of the principal or attorney, while legislation in the Northern Territory restricts an individual's physician from acting as a witness. However, the broad exclusion of persons as witnesses has been criticized by the Alberta Law Reform Institute. In the Institute's opinion:

> A blanket exclusion of all relatives (or near relatives) of the donor [principal] and attorney is unduly restrictive and its underlying premise (namely, that anyone who is related to the donor [principal] or to the attorney is automatically an inappropriate witness) appears to us to be unsound. . . . So long as the . . . [witness] is not the attorney or the attorney's spouse, we believe that this adequately protects the donor's [principal's] interests.[48]

Similar restrictions can be found in analogous Manitoba legislation. For example, *The Powers of Attorney Act* which authorizes the execution of durable powers of attorney for property matters provides that witnesses cannot be "the attorney or the spouse of the attorney"[49] and *The Wills Act* discourages beneficiaries from witnessing the execution of a will by voiding any bequests to a witness or his or her spouse.[50]

In addition to the restrictions just mentioned, special witnesses might be required. For example, it is argued that the use of doctors or lawyers might help to make the individual who wishes to execute a durable power of attorney for health care or an advance directive better aware of the scope of the document and its effect. However, this would involve added complexity[51] and might prevent some individuals from executing a valid directive or power of attorney. On the other hand, special witnessing requirements might be appropriate in more limited circumstances, such as the case of patients in nursing homes or hospitals who depend upon those around them for their every need and who are therefore particularly susceptible to undue influence. A witness such as an ombudsman could involve the courts if he or she doubts the voluntary execution of the document.[52] In addition, he or she could explain the consequences of executing the document.[53] As South Carolina's *Death with Dignity Act* states:

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[46]Advisory Committee on Substitute Decision Making for Mentally Incapable Persons (Ontario), *Report* (1989) 97.

[47]Only Connecticut, Iowa, Maine and Missouri statutes which authorize advance directives do not prescribe eligibility requirements for witnesses.

[48]Alberta Law Reform Institute, *Enduring Powers of Attorney* (Report for Discussion #7, 1990) 42-43. The Alberta Institute would have also included a common law spouse among those ineligible to act as witnesses. As we have noted, however, this Report for Discussion deals with durable powers of attorney for property matters, not for health care decisions.

[49]*The Powers of Attorney Act*, C.C.S.M. c. P97, s. 3(1)(b).

[50]*The Wills Act*, C.C.S.M. c. W150, s. 12(1). Two exceptions to this rule are that where a will is attested by at least two persons who will not benefit under the will, then the devise, bequest, disposition or appointment is not void, and where a court, on application, is satisfied that neither the witness nor his or her spouse exerted undue or improper influence upon the testator, then the court may order that the devise, bequest, disposition or appointment is valid (ss. 12(2) and (3)).

[51]Several law reform agencies which studied this requirement for enduring powers of attorney for property matters rejected this requirement because of the additional complexity: Ontario, Newfoundland, England and Tasmania law reform agencies referred to by the Alberta Law Reform Institute, *Enduring Powers of Attorney* (Report for Discussion #7, 1990) 43, n. 164. The Alberta Law Reform Institute and the Manitoba Law Reform Commission both favoured the special witness requirement: Alberta Law Reform Institute, *Enduring Powers of Attorney* (Report for Discussion #7, 1990) 43; Manitoba Law Reform Commission, *Special, Enduring Powers of Attorney* (Report #14, 1974) 11.

[52]G. Gelfand, "Living Will Statutes: The First Decade", [1987] Wis. L. Rev. 737 at 760.

[53]Vermont's legislation authorizing durable powers of attorney for health care requires this.

> . . . [S]ome patients in skilled or intermediate care nursing facilities may be so insulated from a voluntary decision-making role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of wilfully and voluntarily executing a directive.[54]

South Carolina requires that one of the witnesses to the execution of an advance directive of a nursing home resident be an ombudsman designated by the State Ombudsman, Office of the Governor. Eight other American statutes which authorize advance directives also require special witnesses for patients or residents of nursing homes or hospitals,[55] as does the California and Vermont legislation which authorizes durable powers of attorney for health care. Victoria's Act requires that the individual's physician and another person act as witnesses. Presumably, those responsible for enacting Colorado's advance directive legislation believed that co-patients might also have a conflict of interest, as that Act also prohibits co-patients in a health care facility from acting as witnesses for patients and residents in the same facility.

Since a witness may be asked to attest to the soundness of mind of the maker or principal and voluntary execution of a document, it seems logical that he or she should also be required to be of sound mind. However, such a requirement raises the issue of what effect should be given to a document when it is subsequently discovered that the witness was not of sound mind at the date of execution or that the witness subsequently became incompetent. If a document remains valid notwithstanding the inability of a witness to prove its validity, then the person who executed the document is not penalized. *The Wills Act* of Manitoba takes this approach for testamentary wills; it provides that a will is not invalid simply because at the date of execution or afterward a witness is incompetent to prove the will's execution.[56]

Individuals might also be restricted from acting as witnesses on the basis of age. Similar arguments to those discussed in the section dealing with qualifications for individuals who wish to execute an advance directive or durable power of attorney apply here.

4. Holograph Documents

As discussed in the preceding section, witnesses can help to ensure the validity of an advance directive or durable power of attorney for health care and can attest to the soundness of mind of the maker or principal and to the voluntary execution of the document. However, as beneficial as witnesses may be, there may be times when even a single witness is not available. Rather than deny the use of these documents to an individual who lacks an available witness, it may also be appropriate to recognize them in holograph form, that is, entirely in the handwriting of and signed by the maker, without any witnesses. In Manitoba, holograph documents are accepted as testamentary wills.[57] Amongst existing legislation which governs advance directives and durable powers of attorney for health care, only Missouri's legislation permits the holograph execution of advance directives.

5. Statutory Form

Typically, legislation which authorizes advance directives and durable powers of attorney for health care provides a statutory form for the document. Some examples are set out in

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[54]South Carolina, §§44-77-60.

[55]Arkansas, Connecticut, Delaware, District of Columbia, Georgia, New Hampshire, Oregon and South Carolina.

[56]*The Wills Act*, C.C.S.M. c. W150, s. 11.

[57]*The Wills Act*, C.C.S.M. c. W150, s. 6.

Appendix B. These forms usually contain an introductory or explanatory section stating the basic purpose of the instrument, the extent of the attorney's power (for durable powers of attorney for health care), that the document takes effect after the maker or principal becomes mentally incompetent to make his or her personal medical decisions and the maker's or principal's right to revoke the instrument. The form then authorizes or refuses to authorize the provision of specified medical treatment. In some statutory forms, blank spaces are available for the individual to fill in the specific medical procedures which he or she wishes to authorize or not authorize. Finally, most statutory forms provide space for the signatures of the maker or principal and witnesses. The mandatory use of a statutory form ensures that the document will be easily recognized by a physician or other person who is asked to give it effect and that the content of the document falls within the scope contemplated by the authorizing legislation. Of course, making the use of a statutory form mandatory may result in many documents which do not conform being found to be invalid.

6. Substantial Compliance

The formalities which surround the execution of an advance directive or durable power of attorney for health care and the requirement that an individual comply with a statutory form are intended to ensure that the document embodies the true intentions of its maker and that his or her intentions are clearly communicated to persons who are asked to give effect to the document. However, excessive mandatory requirements as to formality and form may result in advance directives and durable powers of attorney for health care being rarely used or being held to be invalid for non-compliance.[58]

These problems could be minimized if the formal requirements were simplified. However, while simplification might eliminate some difficulties, requiring absolute adherence to even minimum requirements could invalidate some documents. In addition, as formalities for execution and statutory forms fulfil useful purposes, their reduction or elimination seems inadvisable. An alternative approach which would alleviate the harshness of absolute compliance is to require only substantial compliance, so that a defect in the requirements of execution or form would not automatically invalidate the document.

Most American legislation which authorizes advance directives permits substantial compliance with the recommended statutory form. In the United States, only California requires absolute compliance; outside the United States, the Northern Territory requires absolute compliance with its statutory form.[59] Similarly, three of the five American jurisdictions which authorize durable powers of attorney for health care in a special statute permit substantial compliance with the statutory form.[60] The *Uniform Act* also provides a sample form to which documents *may* comply.[61] Precedent for substantial compliance with the formalities of execution can already be found in Manitoba for testamentary wills.[62]

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[58]Alberta Law Reform Institute, *Enduring Powers of Attorney* (Report for Discussion #7, 1990) 30.

[59]*Natural Death Regulations, 1989*, No. 14, s. 2.

[60]Illinois, Nevada and Vermont.

[61]*Uniform Act*, §2. The comment to section 2 explains that a simple form was chosen because it was intended "to serve only as an example of a valid declaration [and a] more elaborate form may have erroneously implied that a declaration more simply constructed would not be legally sufficient . . . [and because the] simple structure and specific language attempt to provide notice of exactly what is to be effectuated through these documents to those persons desiring to execute a declaration and the physicians who are to honor it."

[62]*The Wills Act* provides that where a court is satisfied that a document or writing embodies the testamentary intentions of the deceased, it can order that the will is effective as though it had been executed with all the formal requirements of the Act: *The Wills Act*, C.C.S.M. c. W150, s. 23(a). The change to the Act was based on one of our earlier Reports: Manitoba Law Reform Commission, *"The Wills Act" and the Doctrine of Substantial Compliance* (Report #43, 1980).

Unfamiliarity with legislative requirements will be particularly problematic for individuals who execute an advance directive or durable power of attorney for health care outside of Manitoba and subsequently want the document to be given effect within Manitoba. Alaska, Arkansas, Maine and Illinois legislation provides that directives which are executed outside the state are valid if they comply with the requirements of the state in which they were executed; Vermont's legislation which authorizes durable powers of attorney for health care provides the same for powers of attorney executed outside of Vermont. Of course, documents which comply with the requirements of the foreign jurisdiction may not always be given effect, despite such a permissive provision, since many persons in the local jurisdiction who are asked to give effect to the document would be unfamiliar with the requirements of the foreign jurisdiction and may therefore be hesitant to give effect to it. As an alternative, legislation could provide that directives which comply with the requirements of the local jurisdiction will be valid.[63] However, this statement of the validity of directives which are executed outside the jurisdiction and which substantially comply with local laws seems to be unnecessary in statutes which provide that a document which substantially complies with the statutory form is valid.

7. Physical Inability

A person may be able to understand an advance directive or durable power of attorney for health care but be unable to execute the document due to a physical disability, illness, illiteracy or other circumstance. It seems fair that these individuals should have the same opportunity to benefit from the use of these documents as do persons who are physically able to execute these documents. To achieve this objective, another person could be permitted to sign the document on behalf of the disabled person. To ensure that the substitute follows the directions of the maker or principal, the substitute could be required to sign in the presence of and at the direction of the maker or principal. This would correspond with provisions in Manitoba's *Wills Act*.[64]

It may be as appropriate for restrictions to be placed on who can be named as a substitute signer as it is for qualifications for witnesses. Certainly, it is necessary to guard against forgery. However, there is not much support for such requirements in existing legislation. Of the 21 American statutes which permit a substitute to sign an advance directive on behalf of a person who is unable to sign, only the Colorado, Florida and Minnesota statutes place restrictions on who can act as a substitute.[65] Colorado's legislation bars persons who are prohibited from acting as witnesses (with the exception of co-patients in health care facilities); Florida's and Minnesota's legislation provide that a witness shall sign the document if the maker is physically unable to sign.

Individuals who are physically unable to execute a document could also benefit from the use of an advance directive or durable power of attorney for health care if their oral and non-verbal statements could be accepted as a binding communication of their wishes for future care or the appointment of an attorney. The greatest concern with oral or non-verbal communications is obviously their reliability. It is difficult for most people to recall accurately another person's statements, especially after a long interval; it may be more difficult for a witness to interpret and recall accurately another individual's non-verbal communications. In addition, relatives are

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[63]Maine, Illinois, Hawaii and Montana legislation provides for this.

[64]*The Wills Act* provides that a testamentary will may be signed at its end by "some other person in the presence and by the direction of the testator" (s. 4(a)). The testator must acknowledge the substitute's signature in the presence of two or more witnesses (present at the same time) who must then attest to and subscribe the will in the presence of the testator: *The Wills Act*, C.C.S.M. c. W150, s. 4. The Act also permits a substitute to execute a holograph will on behalf of a member of the Canadian Forces who is on active service: *The Wills Act*, C.C.S.M. c. W150, s. 5(1).

[65]G. Gelfand, "Living Will Statutes: The First Decade", [1987] Wis. L. Rev. 737 at 762.

often the only witnesses of an individual's prior statements and they may be motivated by self-interest to fabricate a statement. For this reason, one commentator suggests that reports of relatives should be corroborated.[66] However, even with corroboration, the unreliability of oral statements or non-verbal communications would likely make many physicians reluctant to rely upon them. Notwithstanding this difficulty, Texas permits advance directives to be communicated in any manner, as does Victoria; Florida and Virginia permit their oral communication. Louisiana restricts the use of oral or non-verbal advance directives to adults who have a terminal and irreversible condition and requires the physician to record why the individual could not execute a written directive.

D. PUBLICATION

An advance directive or durable power of attorney for health care can only be effective if the person who must observe it is aware of the document's existence. One way of ensuring this is to require that the person who executes a document carry a copy at all times. Medical professionals would have ready access to the document and its possession by the maker might reassure the care giver of the maker's "continuing and current" wish that it be followed, even if it was executed some time ago.[67]

Another way that medical professionals can be made aware of advance directives and durable powers of attorney for health care is for persons with knowledge of a document to convey their knowledge to subsequent care givers. For example, where an individual with an advance directive gives a copy to the operator of the nursing home where he or she resides, the nursing home operator could pass on a copy in the event of a subsequent transfer to a hospital. Hospital care givers then would be aware of the patient's wishes for future medical treatment; this would be particularly beneficial in an emergency where health care professionals may be unfamiliar with the individual and would otherwise have to provide treatment without any instruction. Minnesota legislation contains a provision which stipulates that health care providers must try to ensure that a document is honoured by subsequent care givers.

A person who has executed an advance directive or durable power of attorney for health care could also help to ensure that interested persons know about his or her advance directive by providing them with a copy. It does not seem unreasonable that the person most concerned that the document be respected should bear this responsibility. However, a recent study suggests that it is more appropriate to require physicians and hospitals to initiate discussions about durable powers of attorney for health care and advance directives than it is to place the responsibility of notification on patients.[68] The study found that most patients are willing to discuss life-sustaining treatment with their physicians but will not initiate a discussion and that some physicians are reluctant to discuss future medical treatment, particularly the refusal of life-prolonging treatment. In addition, the study notes that an early inquiry about whether a patient has executed an advance directive or durable power of attorney for health care could prevent treatment being administered without knowledge of the document. The study concludes that physicians should be required to initiate discussions so that a dialogue between patient and physician will take place and that, on admission to hospital, individuals should be asked whether they have executed an advance directive or durable power of attorney for health care.[69] The

[66]G. Gelfand, "Living Will Statutes: The First Decade", [1987] Wis. L. Rev. 737 at 759-760.

[67]*Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 at 337 (Ont. C.A.): "The fact that a card of this nature [Jehovah's Witness card] was carried by her can itself be taken as verification of her continuing and current resolve to reject blood 'fully realiz[ing] the implications of this position'."

[68]S. Van McCrary and J.R. Botkin, "Hospital Policy on Advance Directives" (1989), 262 J.A.M.A. 2411.

[69]S. Van McCrary and J.R. Botkin, "Hospital Policy on Advance Directives" (1989), 262 J.A.M.A. 2411 at 2413 and 2414, referring to R.H. Shmerling, S.E. Bedell, A. Lilienfeld and T.L. Delbanco, "Discussing cardiopulmonary resuscitation: a study of elderly outpatients" (1988), 3 J. Gen. Intern. Med. 317.

authors of the study considered that the prevention of some difficult cases outweighs the small burden to hospitals of a few extra questions in the admission process. As for the anxiety which might be caused by including questions about these documents in the admission process, the study suggested that this could be minimized if questions about these documents are routinely included so that a patient could not draw an inference that he or she is in a high risk group.

While the merits of having medical professionals determine whether a person has executed an advance directive or durable power of attorney for health care during the hospital admission process are apparent and while this approach is supported in the medical literature,[70] most American legislation which authorizes advance directives places the burden on the patient to notify care givers about an advance directive. As a result, most hospitals in the United States rely on notification by patients. A survey of hospitals showed that only 4% ask patients or a selected group of patients during the admission process whether they have executed an advance directive or durable power of attorney for health care, while 63% rely on patients to notify the hospital about these documents; the remaining 33% have no policy of inquiry with respect to these documents.[71]

After admission of the patient to a medical facility, many health care professionals become involved in the patient's care. In order that every professional is made aware of the patient's wishes, hospitals could identify patients who have executed an advance directive or durable power of attorney for health care. Most American jurisdictions with legislation for advance directives try to achieve this by requiring that a physician who is notified of a patient's directive make it part of the patient's medical record.[72] As the Comment to the American *Uniform Act* states, this requirement is "critical to the effectuation of the declaration".[73] One jurisdiction, West Virginia, also requires that health care facilities develop a system to identify those patients who have executed an advance directive and who meet the statutory qualifications that govern when a directive will be given effect.

A final method of notifying interested persons of the existence of an advance directive or durable power of attorney for health care is by a registry system. Mandatory registration, either in a government office such as the Public Trustee's office, the Vital Statistics Branch of the Department of Health or a court office, would allow interested parties to determine for themselves whether an individual has executed a health care document. However, a registry system would be expensive, especially since 24-hour access would be necessary. In addition, as we noted in declining to recommend a registry system for the purpose of human tissue donation, "a registry forces physicians to go through an additional mechanism, which may not be up-to-date."[74]

E. ADDITIONAL SAFEGUARDS

A durable power of attorney for health care or an advance directive takes effect after the person who executes it becomes unable to consent to medical treatment. Once an individual is incapacitated, how can he or she be certain that the document will be followed? The answer lies

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[70]The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (1987) 81.

[71]S. Van McCrary and J.R. Botkin, "Hospital Policy on Advance Directives" (1989), 262 J.A.M.A. 2411 at 2412.

[72]Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, Oklahoma, Oregon, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

[73]*Uniform Act*, comment to §2.

[74]Manitoba Law Reform Commission, *The Human Tissue Act* (Report #66, 1986) 48, quoting A.M. Sadler, Jr. and B.L. Sadler, "A Community of Givers, Not Takers" (1984), 15(4) Hastings Cent. Rep. 6 at 8.

in adequate safeguards. In the subsections which follow, safeguards which may provide the necessary assurances will be discussed.

1. Review of Durable Powers of Attorney for Health Care

An attorney who is authorized to make medical treatment decisions for the principal must follow the principal's wishes and, when those wishes are not known, the attorney must act in the principal's best interests. However, an attorney might misinterpret the principal's wishes or might continue to represent the principal after himself or herself becoming incapable of making decisions for the principal. It is even possible that an attorney might intentionally make decisions which are against the principal's wishes or interests. For these reasons, it is essential that there be a mechanism to review an attorney's conduct and to terminate an appointment, where necessary.

Review could be conducted by a court or an institutional ethics committee. Judicial review might be warranted where an attorney allegedly abuses his or her authority; a person who believes that an attorney acts against the principal's wishes or interests should be able to apply to court for an order terminating the attorney's power and appointing a guardian.[75] In cases where the physician or family simply disagree with the attorney's decision, it might be more appropriate for an institutional ethics committee to review an attorney's decision; such a review might even take place on a routine basis. Certainly, an institutional ethics committee can generally make decisions more rapidly than a court as it can convene more easily. In addition, because an institutional ethics committee is closer to the treatment setting, its decisions may be more sensitive. Its private deliberations may also be more appropriate than the public deliberations of a court given the personal nature of the issues which confront it.[76] Indeed, some courts have indicated that the courtroom is not an appropriate forum for making decisions about an individual's medical treatment. For example, in the Karen Ann Quinlan case, the appellate court appointed her father as guardian and left decisions about the discontinuance of life-sustaining measures to him, together with the other family members and the attending physician in consultation with the hospital ethics committee or similar body, without the need for automatic judicial review.

Legislation in California, Illinois and Rhode Island provides that a court can remove an attorney's power when the attorney authorizes acts which are contrary to the principal's known wishes or best interests or which are illegal. Similar legislation in Nova Scotia provides that a court can terminate an attorney's authority by the appointment of a guardian or can revoke an attorney's authority, substitute another person, grant appropriate relief and order costs where an attorney is incapable of giving consent or directions on the principal's medical treatment. Legislation in the Australian Capital Territory also provides that a court can terminate the durable power of attorney and may appoint the Public Trustee as guardian of the principal.

2. Substitution of an Attorney

An attorney may predecease the principal or may be unwilling or unable to act after the principal becomes unable to execute a new power of attorney. When this happens, the principal is left without someone to represent his or her interests. Of course, an interested person could apply for an order of guardianship. However, a guardianship application is expensive and time-

[75]We suggested this for durable powers of attorney for property matters: Manitoba Law Reform Commission, *Special, Enduring Powers of Attorney* (Report #14, 1974) 13.

[76]President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forego Life-Sustaining Treatment* (1983) 168-169.

consuming and does not allow the principal to select his or her representative. If the principal could name a substitute to replace the attorney who is unable or unwilling to act, he or she could exert greater control over future medical care. This, after all, is common practice in the drafting of testamentary wills; alternative executors or executrices are almost always named. A number of American states provide that a principal may name a substitute attorney in the durable power of attorney for health care.[77]

3. Penalty for Concealment

When a person falsifies, conceals, forges or destroys another person's advance directive or durable power of attorney for health care, the consequences may be disastrous for the person who executed the document. Life-prolonging treatment may be terminated contrary to an individual's wishes, an individual may suffer a prolonged terminal illness or exist for a lengthy period of time in a permanent vegetative state against his or her wishes, or the person's wish that a particular individual represent him or her in making medical care decisions might never be known. These consequences are so serious that a person who falsifies, conceals, forges or destroys these documents with the intention of thwarting the wishes of the maker or principal should be severely penalized.

At present, penalties for the forgery of documents in general do exist in the *Criminal Code*.[78] The *Code* also provides that the falsification, destruction or concealment of documents is a criminal offence where the falsification or destruction was done with the intent to defraud and the concealment (of one's own property) was done with the intent to defraud creditors.[79] However, concealment of another's property is not addressed. In addition, there may be a variety of reasons besides an intent to defraud creditors for a person to conceal an advance directive or durable power of attorney for health care. For example, a person might want to control the individual's treatment or might disagree for ethical reasons with the maker's direction to terminate life-prolonging treatment. Accordingly, the *Criminal Code* might be amended to criminalize the concealment of these important documents. In the alternative, any provincial legislation which might be enacted to authorize advance directives and durable powers of attorney for health care could itself provide a penalty for the concealment of these documents.

4. Freedom from Influence of Insurers and Health Care Providers

Some health care facilities in the United States have ethical or religious policies against the withholding and withdrawal of food and fluid from patients.[80] No doubt this is true of some Canadian health care facilities as well. It is likely that these facilities would prefer not to admit a patient whose advance directive or durable power of attorney for health care refuses artificial feeding and hydration to prolong his or her life.

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[77]Illinois, Minnesota, Nevada, Rhode Island and Vermont.

[78]*Criminal Code*, R.S.C. 1985, c. C-46, s. 366.

[79]*Criminal Code*, R.S.C. 1985, c. C-46, ss. 397 and 392(a)(ii).

[80]In one case, a hospital requested that a patient who was refusing artificial feeding and hydration leave the hospital. When the patient refused to leave, the hospital brought an action to compel her to leave. The court ruled that, given the circumstances, which included that the patient was notified 15 months after her admission of the hospital's policy on the withholding of food and fluids, it was unreasonable to require that she be transferred to another hospital. The court compelled the hospital to cooperate with her refusal of food and indicated that the patient's right to refuse treatment prevailed over the institution's policy, even when another facility was available that was willing to comply. The court did not rule out the possibility that in another case a court may find it necessary to order the transfer of a patient to another facility in order to have his or her wishes for future medical treatment fulfilled: *In re Requena*, 517 A.2d 886 (N.J. Super. Ct. Ch. Div. 1986), aff'd 517 A.2d 869 (App. Div. 1986).

Similarly, disability and life insurers might prefer to decline to insure individuals who have an advance directive or durable power of attorney for health care which does not benefit the insurer. Disability insurers might prefer to insure an individual who has an advance directive or durable power of attorney for health care which refuses rather than requests life-prolonging treatment, as the period over which disability benefits would have to be paid would be shorter. Life insurers, on the other hand, might prefer to insure an individual who has an advance directive or durable power of attorney for health care which directs that all life-prolonging procedures be administered rather than terminated, so as to delay the payment of insurance proceeds.

These scenarios are speculative at best. However, in order to protect the individual's right to determine future medical care without undue influence from others, it might be advisable to prohibit health care facilities and insurers from premising their services on the existence or content of an individual's advance directive or durable power of attorney for health care. Such a prohibition is commonly found in American statutes which authorize advance directives. For example, the Texas *Natural Death Act* provides:

> (b) The making of a directive . . . shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.
>
> (c) No physician, health facility, or other health provider, and no health care service plan, or insurer issuing insurance, may require any person to execute a directive as a condition for being insured for, or receiving, health care services nor may the execution or failure to execute a directive be considered in any way in establishing the premiums for insurance.[81]

5. Determination of Mental Capacity

According to the principle of self-determination, an individual can make personal decisions about health care while competent to consent to medical treatment. When an individual loses the ability to understand the nature and consequences of proposed treatment, mechanisms such as the durable power of attorney for health care and advance directive can permit him or her to exert some control over treatment. It may be easy for an attorney to determine the point at which the principal becomes unable to make medical care decisions, that is, the point at which he or she is authorized to represent the principal in making treatment decisions. Similarly, it may be easy for a physician to know when an individual can no longer make treatment decisions, that is, when he or she should look to the individual's advance directive for consent to medical treatment. A comatose state is an obvious example. However, in many cases, it may be difficult for an attorney or physician to know whether an individual is still competent to make personal medical decisions.

One suggestion is that a determination of the maker's or principal's mental capacity be made by two or more independent assessors, each of whom would report on the individual's capacity. The reports would be served on the individual by an advocate who would attempt to make the individual aware of its significance and his or her rights. The advocate would try to ensure that the individual's legal and human rights are recognized and would assist him or her in receiving health and social services of his or her choice.[82] Another suggestion is that the maker

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[81]Texas, §8.

[82]Advisory Committee on Substitute Decision Making for Mentally Incapable Persons (Ontario), *Report* (1989) 139-140.

or principal should be able to name a person (who might be the attorney) to judge his or her mental capacity to make decisions.[83] As the Alberta Law Reform Institute stated:

> If . . . [principals] have sufficient confidence in someone's ability to judge when they are incapable of managing their affairs, they should be free to name that person in the power of attorney. Indeed, in many cases a family member, or close friend, who is familiar with the donor's habits and personality will be in a better position than a physician to judge when the . . . [principal] is no longer capable of managing his or her affairs.[84]

If the maker or principal disagreed with the named person's assessment of his or her mental capacity and was in fact still mentally capable of making medical decisions, he or she could revoke the document and, in the case of a durable power of attorney for health care, appoint another person as attorney, or name another person to make the determination of his or her mental incapacity.[85] Of course, an individual's capacity to consent to medical treatment could be determined by the courts as it is for guardianship proceedings. However, this would involve the expense, delay, lack of privacy and stresses to the family which are associated with court proceedings.

F. REVOCATION

Permitting revocation of an advance directive or durable power of attorney for health care allows an individual to change his or her mind about who should make future medical care decisions and what those decisions should be. The ability to change one's mind makes these instruments more flexible and therefore promotes their more widespread use. For this reason, it is advisable that legislation provide for revocation. In fact, with two exceptions, all legislation which authorizes advance directives or durable powers of attorney for health care permits the person who executes a document to revoke it.[86] In this section, we will consider the issues which relate to revocation.

Probably the most difficult issue which relates to revocation concerns whether some level of mental competence should be required for a person to revoke a durable power of attorney for health care or an advance directive. A requirement for some level of competence, for example, the same competence which is required to execute the original document, would help to ensure that individuals understand the consequences of revocation before being allowed to revoke. Only a few American states adhere to this approach.[87] An alternative is to allow an individual to revoke an instrument at any time without regard to mental state or competence. This option addresses the concern that a restriction on an individual's ability to revoke could result in the early death of a person who has changed his or her mind about a refusal of life-prolonging treatment. It is thought better to err on the side of continued life. However, this assumes that these instruments will be used only to refuse treatment; they may well request the continuance of treatment instead. It also raises the problem that an individual who revokes his or her advance directive or durable power of attorney for health care and who subsequently wants to execute a new document cannot do so until he or she regains the competence required to execute a document. If the individual never regains the necessary competence to execute another instrument, he or she would be without a binding expression of his or her wishes[88] and decisions

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[83]Advisory Committee on Substitute Decision Making for Mentally Incapable Persons (Ontario), *Report* (1989) 140.

[84]Alberta Law Reform Institute, *Enduring Powers of Attorney* (Report for Discussion #7, 1990) 85-86.

[85]Alberta Law Reform Institute, *Enduring Powers of Attorney* (Report for Discussion #7, 1990) 86.

[86]Connecticut legislation which authorizes advance directives and the Australian Capital Territory's legislation which authorizes durable powers of attorney for health care contain no provision for revocation.

[87]Mississippi's legislation which authorizes advance directives requires that a person be of sound mind and California's legislation which authorizes durable powers of attorney for health care requires that the principal have the competence to execute a durable power of attorney for health care in order to revoke.

[88]G. Gelfand, "Living Will Statutes: The First Decade", [1987] Wis. L. Rev. 737.

about medical treatment would have to be made by his or her family and physicians or a court-appointed guardian.

Besides competence to revoke, the manner in which a document can be revoked must be considered. Revocation by any means would provide the greatest flexibility. On the other hand, revocation only by specified means might provide greater certainty about whether a document has been revoked. A few American statutes which authorize advance directives permit revocation in any manner,[89] while the remaining statutes which authorize advance directives and durable powers of attorney for health care specify acceptable methods of revocation: most of these permit revocation by physical destruction or a written or oral communication. Of course, permitting oral communication of a revocation raises the concerns respecting proof that were discussed with respect to the oral communication of an advance directive or durable power of attorney for health care. Some specificity as to what constitutes an acceptable method of revocation can also be found in Manitoba's legislation which governs testamentary wills. *The Wills Act* sets out a number of acceptable methods of revocation: a later writing which shows an intention to revoke (made in accordance with the provisions of *The Wills Act*), the burning, tearing or other destruction of the original with the intention to revoke (by the testator or another person in the presence and at the direction of the testator), or a later valid will.[90]

The problem which confronts individuals who have an advance directive or durable power of attorney for health care and who are or later become unable to write or physically destroy the original document should also be addressed. Individuals who can speak but cannot write or physically destroy a document could revoke if legislation permits oral revocation. An alternative is to allow another person to destroy the original or execute a revocation on behalf of the disabled individual; this would provide physically disabled individuals with the same ability to revoke which is allowed to other persons. For example, Utah legislation provides that an advance directive "may be revoked at any time by . . . the person or persons who signed a directive on behalf of a declarant."[91] The disabled person would be protected if the person who acts on his or her behalf does so in his or her presence with witnesses.[92] Georgia and Louisiana also specifically address the problem that faces a person who can neither write nor speak: that legislation allows the nonverbal communication of a revocation.

Another consideration is whether procedural formalities should be necessary for a written revocation. Procedural formalities provide the same benefits for the revocation of a document as were discussed earlier for the execution of advance directives or durable powers of attorney for health care. Briefly, they help to assure interested persons that a document has been revoked and help to prevent fraud and undue influence. However, as with the execution of the original document, procedural formalities may be detrimental to individuals who cannot meet the requirements. For example, a qualified witness may not be available. A compromise which provides the benefits of procedural formalities without their detriments might be achieved by allowing a written revocation to substantially comply with statutory requirements. This approach can be found in Mississippi's legislation. As we noted earlier, substantial compliance is also permitted for the revocation of testamentary wills in Manitoba; a court need only be satisfied that the writing embodies the testator's intention to revoke his or her will.[93]

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[89]Alaska, Arkansas, Iowa, Maine, Missouri, Montana, Minnesota, North Carolina and the *Uniform Act*.

[90]*The Wills Act*, C.C.S.M. c. W150, s. 16.

[91]Utah, §75-2-1111(1).

[92]Witnessing requirements are crucial both for the protection of an individual who wishes to revoke his or her document and to provide assurance as to the validity of a revocation to those who must rely on the revocation: G. Gelfand, "Living Will Statutes: The First Decade", [1987] Wis. L. Rev. 737.

[93]*The Wills Act*, C.C.S.M. c.W150, s. 23(b).

Another matter which must be considered is automatic revocation. This refers to revocation which occurs automatically at a specified time after the date of execution of an advance directive or durable power of attorney for health care or to revocation on the happening of a specified event, such as divorce or annulment where the individual has designated his or her spouse as attorney. An individual must re-execute the document or execute a new document after the time period expires or after the divorce or annulment to maintain a valid document. Legislation in several American jurisdictions provides that at a specified time after execution the document is revoked.[94] California, Nevada and Minnesota legislation which authorizes durable powers of attorney for health care also provides that after a divorce the designation of a former spouse as attorney is revoked.[95] Vermont legislation which authorizes durable powers of attorney for health care provides, on the other hand, that the entire document in which the spouse is designated as the attorney is revoked on a divorce.

A benefit of automatic revocation is that it forces an individual to reconsider and update a document at a later time after its execution. A disadvantage is that an individual may forget to execute a new document. A document might also become invalid while an individual is not competent to execute a new one. Of course, the latter problem can be addressed if the original document were to remain valid until the individual regains his or her capacity to execute a new document, as is provided in California and Rhode Island legislation for durable powers of attorney for health care.[96] The problem of individuals forgetting to execute a power of attorney for health care after a divorce or annulment could be ameliorated by allowing an individual to appoint a substitute attorney to act in place of the ex-spouse following a divorce or annulment. Of course, these suggestions would not assist those individuals who simply forget to execute a new document after his or her document expires, nor those individuals who do not name a substitute attorney. In any event, in all likelihood, not every individual who executes a new document would inform interested persons about the newly executed document.

A final matter that pertains to revocation is publication. In the same way that an advance directive or durable power of attorney for health care can be effective only when interested persons are aware of its existence, so too the revocation of these documents can be effective only when interested persons are aware of the revocation. As was discussed earlier for the original documents, the burden of notifying interested persons about a revocation could rest with the individual who revokes the document or hospitals and professionals could be required to inquire about revocation. Similarly, a registry system could be used to notify interested persons about the revocation of a document.[97] Since many medical professionals are involved in treating an individual, notification of all interested persons within a health care facility is better assured if a revocation is made part of the patient's medical record by the professional who is notified of the revocation.

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[94]California - advance directives; California and Rhode Island - durable powers of attorney for health care.

[95]The appointment of a spouse as executor or executrix of a testamentary will is treated in a parallel manner in Manitoba. In Manitoba, the appointment of a spouse as executor or executrix is treated as if the former spouse predeceased the testator; in effect, the appointment of the former spouse is revoked. The will itself is not revoked by a divorce unless a contrary intention appears in the will: *The Wills Act*, C.C.S.M. W150, ss. 18(1) and (2).

[96]California and Rhode Island legislation provides that a durable power of attorney expires after 7 years unless the principal is incompetent to make his own health care decisions at the end of that period, in which case the power continues until he regains that capacity.

[97]See our earlier discussion at 35.

G. MISCELLANEOUS MATTERS

1. Common Law Rights Retained

Some critics believe that the authorization of advance directives in legislation might prompt health care professionals to make several incorrect assumptions. They believe that physicians and other health care professionals will assume that individuals who either have not executed an advance directive or who, having executed an advance directive, have subsequently revoked it want life-prolonging treatment to be undertaken or continued in all circumstances and that it is their duty to administer life-prolonging treatment to these individuals, no matter how useless such treatment might be. These beliefs are based, in part, on the fact that, in jurisdictions with legislation authorizing advance directives, their use is commonly restricted to terminally ill patients who wish to communicate the refusal of life-prolonging medical treatment. However, such beliefs are unfounded, since advance directives might just as easily be used to convey a consent to future medical treatment; furthermore, individuals may have failed to execute an advance directive for reasons other than a desire to have life-prolonging treatment administered in every circumstance. For example, an individual may simply have never addressed his or her mind to the issue.

A recent American study indicated that, in general, physicians do not assume that individuals who have not executed an advance directive want life-prolonging treatment to be administered, nor do they administer more treatment than they otherwise would to these individuals.[98] Although these findings are reassuring, to alleviate any remaining doubts, it may be prudent for legislation to provide expressly, first, that assumptions cannot be made about an individual's treatment wishes on the basis that the individual either has or has not executed an advance directive and, second, that the rights created in legislation are cumulative and are not intended to displace the judicially created rights of patients and obligations of physicians which existed prior to the enactment of legislation authorizing advance directives. This latter provision would assure physicians that they are not obliged to administer useless treatment to a patient simply because he or she has not executed or has executed and then revoked an advance directive.

Provisions such as this can be found in most American statutes which authorize advance directives, South Australia's and the Northern Territory's legislation, as well as the *Uniform Act*. The latter provides:

> (d) This [Act] creates no presumption concerning the intention of an individual who has revoked or has not executed a declaration with respect to the use, withholding, or withdrawal of life-sustaining treatment in the event of a terminal condition.
>
> (e) This [Act] does not affect the right of a patient to make decisions regarding use of life-sustaining treatment, so long as the patient is able to do so, or impair or supersede any right or responsibility that a person has to effect the withholding or withdrawal of medical care.[99]

2. Not Suicide

If an individual who refuses future treatment in an advance directive or who instructs his or her attorney to refuse treatment in a durable power of attorney for health care dies after the refusal is honoured, some might view the death as a suicide. If an insurance company chose to do so, it might refuse to pay life insurance benefits. However, in most cases, the withholding or

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[98] J.M. Zinberg, "Decisions for the Dying: An Empirical Study of Physicians' Responses to Advance Directives" (1989), 13 Vt. L. Rev. 445 at 476.

[99] *Uniform Act*, §11(d) and (e).

withdrawal of medical treatment cannot reasonably be considered to be a suicide; it is no more than the individual had the right to instruct while still competent. An express provision in legislation clarifying that the death of a person who refuses medical treatment in an advance directive or who directs his or her attorney to refuse treatment in a durable power of attorney for health care does not, in and of itself, constitute suicide could assist beneficiaries who might otherwise experience difficulties in collecting life insurance benefits. American legislation which authorizes advance directives routinely includes such a provision, as does the American *Uniform Act*. South Australia's and the Northern Territory's legislation also provides for this; those statutes provide that the withdrawal of extraordinary medical treatment from a terminally ill patient in accordance with his or her wishes does not constitute a cause of death.

On the other hand, it is a criminal offence in Canada to counsel another person in the commission of a suicide, or to aid or abet a person to commit suicide.[100] An attorney who, acting on behalf of his or her principal, directs the withdrawal or withholding of medical treatment, would need protection to avoid prosecution for aiding or abetting a suicide. Since criminal law falls within federal jurisdiction, the federal government would have to be asked to amend the *Criminal Code* to provide an exception for attorneys who follow the instructions in a durable power of attorney for health care.

3. Presumption of Validity of Documents

The authorization of advance directives and durable powers of attorney for health care forces physicians who are asked to give effect to these documents to consider their validity. A cautious physician would want to know that an individual who executed an advance directive or durable power of attorney for health care was mentally competent, that he or she executed the document willingly and without undue influence and that all statutory requirements for execution were followed. Since such a determination might involve an interpretation of the document as well as legal issues, physicians might feel obliged to consult with lawyers, hospital administrators and perhaps even hospital ethics committees. Such a determination would be a tremendous burden to physicians. This could be eliminated by allowing physicians to assume, in the absence of notice to the contrary, that the individual who executed a document was of sound mind at the date of its execution and that the document complies in form and content with the legislation requirements. A number of American statutes which authorize advance directives contain provisions of this nature.[101]

4. Amendments to *The Human Tissue Act*

If legislation which authorizes durable powers of attorney for health care is enacted, an anomaly will be created between it and *The Human Tissue Act*:[102] an individual will be able to appoint a person to make health care decisions for himself or herself until his or her death but, after death, the individual will have no choice in who can direct a human tissue donation on his or her behalf. At present, the nearest relative is authorized by *The Human Tissue Act* to direct a donation where the individual has not communicated a wish prior to death.[103] We must address our minds to whether *The Human Tissue Act* should be amended to authorize an attorney who has been appointed by a durable power of attorney for health care to have priority over relatives

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[100] *Criminal Code*, R.S.C. 1985, c. C-46, s. 241.

[101] Alabama, Delaware, District of Columbia, Illinois, Kansas, New Mexico, Oregon, West Virginia and Wisconsin.

[102] *The Human Tissue Act*, C.C.S.M. c. H180.

[103] *The Human Tissue Act*, C.C.S.M. c. H180, s. 3(1). Where a relative is not available, the person who is in lawful possession of the body or the Inspector of Anatomy may direct a donation.

to direct a human tissue donation. Illinois has the only legislation which addresses this issue; it authorizes an attorney to make decisions on human tissue donation.

Allowing individuals to make decisions about their future medical treatment, including decisions to refuse life-prolonging treatment, countenances the withdrawal or withholding of life-prolonging treatment in accordance with those wishes. *The Human Tissue Act* should recognize this fact by providing that physicians who withdraw or withhold life-prolonging medical treatment should not participate in organ transplantation from that individual.[104]

[104]At present, *The Human Tissue Act* provides only that a physician who participates in a determination of death may not participate in an organ transplantation from that patient: *The Human Tissue Act*, C.C.S.M. c. H180, s. 8(3).

CHAPTER 4

CONCLUSION

At the beginning of this Discussion Paper, we set out two examples of situations in which the wonders of modern medicine have created legal problems which did not exist scant years ago. The advance directive and the durable power of attorney for health care have been put forward as two mechanisms to deal with these problems. With the publication of this Discussion Paper, we hope to receive submissions on whether these mechanisms would truly be a useful addition to the law. We also seek the guidance of interested people in the best way to ensure that these mechanisms are both effective and respectful of the needs of their potential users, their families, health care professionals and others.

In order to assist those readers who wish to comment on the matters raised in this Paper, we have formulated the following list of specific questions; reference is also made to the pages of the Discussion paper where the issues are discussed. However, this list is not intended to be exhaustive. We would welcome comments on all aspects of providing legal effect to the previously expressed wishes of individuals who are no longer competent to provide medical consent, whether raised in this Discussion Paper or not.

Question 1

Should the law be reformed to permit the creation of a mechanism which would give legally binding effect to the wishes of a person not competent to make decisions about medical treatment which were expressed at a time when he or she had such competence? (pp. 11-13)

Question 2

If so, what mechanism or mechanisms should be adopted? The advance directive, the durable power of attorney for health care or both? Is some other mechanism preferable? (pp. 14-18)

Question 3

In adopting one or more of these mechanisms:

(a) What should their scope be? (pp. 19-24)

(b) What obligations and immunities should health care professionals and medical facilities have in following them? (pp. 24-26)

(c) Who should be permitted to execute one? Should substitute execution be permitted? (pp. 26-27 and 33-34)

(d) What requirements for witnesses should there be? (pp. 28-31)

(e) Should holograph documents be recognized? (p. 31)

(f) Should a statutory form be required or permitted? (pp. 31-32)

(g) Should substantial compliance with any formalities associated with execution (as opposed to absolute compliance) be taken as sufficient? (pp. 32-33)

(h) What steps, if any, should be taken to ensure that a person who is asked to give effect to such a mechanism is aware of the document? (pp. 34-35)

(i) Should health care providers and insurers be prohibited from premising their services on an individual executing such a document? (pp. 37-38)

(j) How should the commencement of an attorney's authority or the effective date of an advance directive be determined? (pp. 38-39)

(k) What should the requirements for revocation be? (pp. 39-41)

Question 4

Specifically respecting durable powers of attorney for health care:

(a) Who should be eligible for appointment as an attorney? (pp. 27-28)

(b) Should the decisions of attorneys be reviewable? (p. 36)

(c) Should a person who executes a durable power of attorney be permitted to name a substitute attorney? (pp. 36-37)

APPENDIX A

STATUTORY REFERENCES

Part 1: American Statutes which Authorize Advance Directives

Alabama: Ala. Code §§22-8A-1 to 22-8A-10 (1984).

Alaska: Alaska Stat. §§18.12.010 to 18.12.100 (Supp. 1986).

Arizona: Ariz. Rev. Stat. Ann. §§36-3201 to 36-3210 (1986).

Arkansas: 1987 Ark. Acts 713.

California: Cal. Health & Safety Code §§7185 to 7195 (Supp. 1988).

Colorado: Colo. Rev. Stat. §§15-18-101 to 15-18-113 (Supp. 1986).

Connecticut: Conn. Gen. Stat. §§19a-570 to 19a-575 (1987).

Delaware: Del. Code Ann. tit. 16, §§2501 to 2509 (1983).

District of Columbia: D.C.Code Ann. §§6-2421 to 6-2430 (Supp. 1988).

Florida: Fla. Stat. Ann. §§765.01 to 765.15 (West 1986).

Georgia: Ga. Code Ann. §§88-4101 to 88-4112 (Harrison 1984 and Supp. 1988).

Hawaii: Haw. Rev. Stat. §§327D-1 to 327D-27 (Supp. 1986).

Idaho: Idaho Code §§39-4501 to 39-4509 (1985, Supp. 1986 and 1988).

Illinois: Ill. Ann. Stat. ch. 110 1/2, para. 701 to 710 (Smith-Hurd Supp. 1988).

Indiana: Ind. Code Ann. §§16-8-11-1 to 16-8-11-17 (Burns Supp. 1986).

Iowa: Iowa Code Ann. §§144A.1 to 144A.11 (West Supp. 1988).

Kansas: Kan. Stat. Ann. §§65-28,101 to 65-28,109 (1985).

Louisiana: La. Rev. Stat. Ann. §§40:1299.58.1 to 40:1299.58.10 (West Supp. 1988).

Maine: Me. Rev. Stat. Ann. tit. 22, §§2921 to 2931 (Supp. 1986).

Maryland: Md. Health-Gen. Code Ann. §§5-601 to 5-614 (Supp. 1986).

Minnesota: 1989 Minn. Sess. Law Serv. 3 (West).

Mississippi: Miss. Code Ann. §§41-41-101 to 41-41 121 (Supp. 1988).

Missouri: Mo. Ann. Stat. §§459.010 to 459.055 (Vernon Supp. 1987).

Montana: Mont. Code Ann. §§50-9-101 to 50-9-206 (1985).

Nevada: Nev. Rev. Stat. Ann. §§449.540 to 449.690 (Michie 1986 and Supp. 1988).

New Hampshire: N.H. Rev. Stat. Ann. §§137-H:1 to 137-H:16 (Supp. 1986).

New Mexico: N.M. Stat. Ann. §§24-7-1 to 24-7-11 (1986).

North Carolina: N.C. Gen. Stat. §§90-320 to 90-322 (1985).

Oklahoma: Okla. Stat. Ann. tit.63, §§3101 to 3111 (West Supp. 1987).

Oregon: Or. Rev. Stat. §§97.050 to 97.090 (1987).

South Carolina: S.C. Code Ann. §§44-77-10 to 44-77-160 (Law. Co-op. Supp. 1987).

Tennessee: Tenn. Code Ann. §§32-11-101 to 32-11-111 (Supp. 1986).

Texas: Tex. Rev. Civ. Stat. Ann. art. 4590h (Vernon Supp. 1987).

Utah: Utah Code Ann. §§75-2-1101 to 75-2-1118 (Supp. 1986).

Vermont: Vt. Stat. Ann. tit. 18, §§5251 to 5262 (Supp. 1985).

Virginia: Va. Code Ann. §§54-325.8:1 to 54-325.8:13 (Supp. 1987).

Washington: Wash. Rev. Code Ann. §§70.122.010 to 70.122.905 (Supp. 1989).

West Virginia: W. Va. Code §§16-30-1 to 16-30-10 (1985).

Wisconsin: Wis. Stat. Ann. §§154.01 to 154.15 (West Supp. 1988).

Wyoming: Wyo. Stat. §§35-22-101 to 35-22-109 (Supp. 1989).

Part 2: American Statutes Which Authorize Durable Powers of Attorney for Health Care

Separate Statute Authorizes Durable Powers of Attorney for Health Care

California: Cal. Civil Code §§2430 to 2444 (West Supp. 1988).

Illinois: Ill. Ann. Stat. ch. 110 1/2, para. 804-1 to 804-12 (Smith-Hurd Supp. 1988).

Nevada: Nev. Rev. Stat. Ann. §§449.800 to 449.860 (Michie 1987).

Rhode Island: R.I. Gen. Laws §§23-4.10-1 to 23-4.10-2 (1988).

Vermont: Vt. Stat. Ann. tit. 14 §§3451 to 3467 (Supp. 1988).

Appointment of Attorney for Health Care Authorized in General Durable Power of Attorney Statute

Alaska: Alaska Stat. §13.16.332 (1989).

Colorado: Colo. Rev. Stat. §15-14-501 (Supp. 1989).

Maine: Me. Rev. Stat. Ann. tit. 18-A, §5-501 (Supp. 1988).

North Carolina: N.C. Gen. Stat. §32A-1 (1988).

Pennsylvania: 20 Pa. Cons. Stat. Ann. §§5602(a)(8) and (9) and 5603(h) (Purdon Supp. 1989).

Washington: 1989 Wash. Legis. Serv. 211 §25 (West).

Durable Powers of Attorney for Health Care Authorized in Statute Which Authorizes Advance Directives

Arkansas: 1987 Ark. Acts 713, §§1(10), 2.

Delaware: Del. Code Ann. tit. 16, §2502(b) and (c) (1983).

Florida: Fla. Stat. Ann. §765.05(2) (West 1986).

Idaho: Idaho Code §39-4505 (1985, Supp. 1986 and 1988).

Louisiana: La. Rev. Stat. Ann. §40:1299.58.3(C)(1) (West Supp. 1988).

Minnesota: 1989 Minn. Sess. Law Serv. 3 (West) §§3(D)(3), 4(A), (B), (E)(8), 6(B)(2), 8, 9(2).

Texas: Tex. Rev. Civ. Stat. Ann. art. 4590h, §3(e) (Vernon Supp. 1987).

Utah: Utah Code Ann. §75-2-1106 (Supp. 1986).

Virginia: Va. Code Ann. §§54-325.8:4, 54-325.8:6.2 (Supp. 1987).

Wyoming: Wyo. Stat. §35-22-102(d) (Supp. 1989).

Statute Implies That a Durable Power of Attorney May Be Used to Appoint An Agent to Make Health Care Decisions

Indiana: Ind. Code Ann. §16-8-11-14(g)(2) (Burns Supp. 1986).

Hawaii: Haw. Rev. Stat. §327D-26 (Supp. 1986).

Iowa: Iowa Code Ann. §144A.7(1)(a) (West Supp. 1988).

Maryland: Md. Health-Gen. Code Ann. §20-107(d)(Supp. 1988).

Part 3: Other Legislation

Canada

Nova Scotia: *Medical Consent Act*, S.N.S. 1988, c.14.

Australia

Australian Capital Territory: *Powers of Attorney (Amendment) Act 1989*, No. 15 of 1989.

Northern Territory: *Natural Death Act 1988*, No. 51 of 1988.

South Australia: *Natural Death Act, 1983*, No. 121 of 1983.

Victoria: *Medical Treatment Act 1988*, No. 41 of 1988.

APPENDIX B

SAMPLE ADVANCE DIRECTIVES AND DURABLE POWERS OF ATTORNEY FOR HEALTH CARE

Rights of the Terminally Ill or Permanently Unconscious Act, 1987 Ark. Acts 713, §2(b) and (c)

[Declaration in the Event of a Terminal Condition]

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to [withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.][follow the instructions of _____ whom I appoint as my Health Care Proxy to decide whether life-sustaining treatment should be withheld or withdrawn].

Signed this _____ day of _____,_____.
Signature_____
Address_____

The declarant voluntarily signed this writing in my presence.

Witness_____
Address_____
Witness_____
Address_____

[Declaration in the Event of Permanent Unconsciousness]

If I should become permanently unconscious I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to [withhold or withdraw life-sustaining treatments that are no longer necessary to my comfort or to alleviate pain.][follow the instructions of _____ whom I appoint as my health-care proxy to decide whether life-sustaining treatment should be withheld or withdrawn].

Signed this _____ day of _____,_____.
Signature_____
Address_____

The declarant voluntarily signed this writing in my presence.

Witness_____
Address_____
Witness_____
Address_____

Living Wills and Life-Prolonging Procedures Act, Ind. Code Ann. §16-8-12(c) (Burns Supp. 1986)

[Life-Prolonging Procedures Declaration]

Declaration made this ____ day of _____(month, year). I, _____, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life-prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed__ _____

_____

City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years old.

Witness_____ Date_____
Witness_____ Date_____